AN INVESTIGATION INTO THE FAMILY ENVIRONMENT OF THE RECOVERING FEMALE AGORAPHOBIC

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CHAPTER I

INTRODUCTION

Statement of the Problem

Greek mythology (Crowell, 1970) recites the account of the celebrated wrestler, Antaeos. Son of Terra, the Earth, Antaeos was invincible so long as he remained in contact with Earth. This gigantic wrestler overwhelmed all challengers, except Hercules. Hercules encountered Antaeos, and found that it was of no avail to throw him to the ground for he always arose with renewed strength from every fall. Hercules discovered that Antaeos' strength was connected to the earth and if 'disconnected' from the ground, disability ensued. Hercules, thus, lifted Antaeos into the air, rendering him helpless and proceeded to strangle him.

This ancient figure, Antaeos, epitomizes a life restricted to safe places. Not so mythical, however, are the millions of agoraphobics who experience an incapacitating anxiety upon venturing beyond the boundaries of "safety zones." Agoraphobics are defined not only by fear of public places and conveyances but also by their fear of being away from familiar people and places that provide psychological security (Chambless & Goldstein, 1982). This entrapment may transform a successful, outgoing personality into a shattered recluse who finds safety in his house, a favorite chair or couch. To move away from the confines of such safety may result in a disabling anxiety manifesting

itself through tightness in the chest, sweaty palms, an uncontrollable trembling of the hands, a wave of nausea and the urge to flee.

The panic attack serves as the trademark of agoraphobes. In the wake of this burst of anxiety resides a plethora of fears and self-doubts: "am I losing my mind?" "could I be having a nervous breakdown?" "this could be a heart attack!" "I'm probably dying!" "I'm just a weak person" or "it's probably a brain tumor."

The crippling effects of the confusion and self-doubts are exacerbated by the reaction of family members who may lose patience with the agoraphobic member ("Agoraphobics and," 1981). Confused by the bizarre behavior of the agoraphobe, family and friends begin to question why he doesn't "pull himself together." Though initially sympathetic with the agoraphobia, family members may become critical at the inconvenience of the restrictions posed by the illness (Weekes, 1976).

The agoraphobia is further heightened by the paucity of information and general lack of awareness in the medical and mental health community. Agoraphobics have been commonly misunderstood by medical professionals because few physicians were familiar enough with the malady to recognize it ("Agoraphobics and," 1981). Frequently, it is misdiagnosed and agoraphobes have been treated with electroconvulsive therapy, traditional psychotherapy, tranquilizers and even been institutionalized.

Simultaneously, the distress of the agoraphobic sufferer is enhanced by the knowledge that spouses and family members suffer as well. The housebound mother who cannot accompany her daughter to an awards banquet or watch her son participate in sports activities chides herself for her family's disappointment (Frampton, 1974). The increasingly restricted existence leaves family and friends to assume

the agoraphobic's roles and responsibilities. The acute disposition of the malady is likely to impinge on the marital relationship as the ill member is prone to focus preeminently on the agoraphobia while relationships and responsibilities assume only secondary importance. Normal family functioning is interrupted, necessitating a restructuring of family roles.

The family context of the agoraphobic syndrome has largely been ignored. Chambliss and Goldstein (1982) report that "early studies of agoraphobia are mainly psychoanalytically oriented and focus on intrapsychic rather than interpersonal aspects of the syndrome" (p. 77). Gradually, research on the family context of agoraphobia is finding its way into the literature. Even so, the relationships have been researched from the perspective of: family of origin as a causal factor (Webster, 1953; Tucker, 1956; Goldstein & Chambless, 1978); mate selection as affected by agoraphobia (Goodstein & Swift, 1977; Fodor, 1974); and spouses as impacted by treatment (Agulnik, 1970). Admittedly, the interpersonal component has been given some consideration by researchers, but primarily, it seems, in relationship to either etiology or treatment factors.

The Need for Research

Agoraphobia, recently thought to afflict only a small population, has emerged as a far more prevalent health problem (Mathews, Gelder, & Johnston, 1981). Weekes (1976) estimated more than one million Americans suffer incapacitating anxiety on traveling away from the safety of home or being in a crowded place; of being in any situation where the sufferer thinks he may experience overwhelming panic and inability to cope. The ensuing entrapment in effect cripples previously

self-assured and successful individuals and transforms them into fearful, fragile human beings.

The bulk of the literature is weighted towards the treatment aspects of agoraphobia and almost devoid of reference to family management of the problem. In general, those family members directly related to the illness also appear to be lacking in attention from researchers. Addressing the family dynamics of the problem may provide more effective ways to assist agoraphobic families to better understand and more effectively cope with the malady.

In the context of treatment for agoraphobic women, Holm (1982) proposed a multimodal treatment procedure of which marital therapy is a signal component:

> Because the agoraphobic woman's symptoms are strongly connected to a specific, homeostatic collusion pattern between her and her husband, it is essential to include the husband in the treatment. It is important to stimulate his feeling of individuality and bring him to regard his wife's newly won freedom positively. The individuation process is important for both of them; it also helps keep the marriage from being destroyed. Many of the patients who relapse do so because the husband has a difficult time accepting a symptom-free, mature, independent, active and lively woman. (p. 410)

Holm (1982) postulates that to treat the identified patient to the neglect of the context of the illness is to decrease the chances for remediation and to increase the possibility for damaging the family system: "A good result is often contingent upon the marital pattern being worked through and modified" (p. 410).

Beyond a consideration of phobic behavior itself, the tenor of this research project is contextual. The concerns addressed are those of describing the family system and observing regularities, shifts and relative strengths which might contain implications in the treatment of

the agoraphobic family.

The Role of this Research Within the Discipline of Home Economics

Reflecting upon the complexion of home economics, the Fourth Lake Placid Conference reiterated the nature of home economics as

> the study of the laws, conditions, principles and ideals which are concerned on the one hand with man's immediate physical environment and on the other hand with his nature as a social being, and is the study especially of the relation between these two factors. (Budewig, 1964)

Such general statements of mission were further delineated in Home Economics New Directions: A Statement of Philosophy and Objectives (1959) as strengthening family life through educating the individual for family living; conducting research to discover the changing needs of individuals and the means of satisfying those needs. Furthermore, home economics synthesizes knowledge drawn from its research with the physical, biological and social sciences, and applies this knowledge to improving the lives of individuals and families.

Home Economics -- New Directions II (1974) continued in the established tradition of the American Home Economics Association and brought new emphases to the fore under the nomenclature of "family ecosystem." The core of home economics was identified under the ecosystem approach as the study of the reciprocal relations of the family to its natural and man-made environments. Social institutions and physical environments are significant as they both interface with and effect the internal functioning of the family.

Familiarity with the evolutionary process of the near-centenarian, home economics, serves further to secure the place of this research

within this field. Admittedly, interest and research of agoraphobia occurs almost solely within the discipline of psychology. But, to assume the posture that this research falls outside the design and parameters of home economics appears to ignore the avowed multidisciplinary nature of the profession. Brown and Paolucci (1979) urge the profession of home economics to continue to review its mission and point out that it must change to reflect emerging and societal concerns. With agoraphobic dysfunction as a severe malady, impinging upon family systems and related to the larger social network, it emerges as a concern of a home economics professional, specializing in family relations.

Summarily, the dynamic of home economics is its unique perspective in that it provides an integrative approach to research. Professionals within this field synthesizes data from a variety of areas (i.e. sociology, psychology, anthropology, etc.) as they intersect with the family system (Crabtree, 1979).

Overview of the Dissertation

The thrust of this inquiry stands in contrast to those investigations which probe the agoraphobic malady per se. It is concerned, however, with the environment of families in which one of the partners (in this research, the wife) suffers from the malady known as "agoraphobia." It also explores the self-esteem of the agoraphobic and non-agoraphobic spouse, together with family means of coping with the chronic illness. In order to provide a contrast, a control group of non-agoraphobic couples is also examined.

This research began with interviews of four agoraphobics and their spouses. Those non-structured interviews provided the basis for the

quantitative investigation in not only elucidating the idiosyncratic nature of the malaise but in helping to determine the content of the research instrument.

In the ensuing chapters of this dissertation, the ideas discussed within Chapter I are perused via the avenue of related literature. The lion's share of Chapter II is devoted to exploring the issues of agoraphobia: definition, origin, and treatment modalities. Also included in Chapter II is a compendium of the literature regarding families with a chronically ill member. Present in the literature is the significance of the family's reaction to the pervasive illness of a family member. The implication of this response is significant in that the family's definition of the illness may ultimately affect the ill subject's recovery. The general area of family response to chronic illness is further delineated to include family response to mental illness. Again, similar issues began taking shape: family definition of the illness; family attitude toward its ill member and the effects of attitude upon outcome.

Systems Theory provides the theoretical stance of the dissertation. Within Chapter II, this theoretical framework is summarized together with a systemic view of families as effected by chronic illnesses, viz. the critical results of protracted illness upon the identified patient and the entire relational network.

Procedurally, this research began vis-a-vis agoraphobic sufferers and their spouses in an conversational setting. Building upon these interviews, data were collected from agoraphobic and non-agoraphobic (control) populations. Chapter III delineates the instrumentation, data collection and statistical analyses utilized to test the hypotheses. The results of the research project are summarized in Chapter IV

(quantitatively) and Chapter V (qualitatively). The conclusions of the research are coupled with recommendations for further research in Chapter VI.

Hypotheses to be Examined

Numerous publications address phobias in general. Gradually, the particular malady of agoraphobia is surfacing and receiving the attention of researchers. The bulk of this literature, however, appears directed towards treatment approaches to agoraphobia with significant amounts of research centered around etiological concerns. With the preponderance of the literature addressing either the etiological or treatment issues, the available research regarding the family context of agoraphobia may be said to be sparse by comparison.

Systems theory will provide the conceptual framework for this inquiry in it's concern with the identified agoraphobe and the immediate family system. The spouse of the agoraphobic sufferer is critical to the well-being of the ill subject.

Systems theory suggests the perspective of viewing the family as an organism, "composed of mutually dependent parts and processes standing in mutual interaction" (Bertlanaffy, 1934). Implicit in this theoretical perspective is interdependence -- a change in one member of the system will effect change in other parts of the system. Chronic illness, from a systems perspective, views the family dynamically. Illness within the family is, therefore, not isolated to the ill member alone but encompasses the entire family system.

Whereas, the literature reflects agoraphobia as the subject of considerable attention from treatment and etiological perspectives, the current study attempted to focus on the systemic nature of the

agoraphobia. Areas investigated qualitatively include those definitions agoraphobic and non-agoraphobic populations tend to attach to agoraphobic behavior. Further, this research attempted to identify the attitudes with which agoraphobia is greeted (i.e. embarrassment, shame, anger, frustration, etc.). Also, the prognosis both agoraphobics and non-agoraphobics tend to attach to a family with an agoraphobic member was an element of the investigation.

At the base of the quantitative portion of this investigation lie the following hypotheses expressed in the null form:

Hypothesis 1: There are no statistically significant relationships between the incidence, duration, severity, and age at onset of agoraphobia in the wife and her self-esteem.

Hypothesis 2: There are no statistically significant relationships between the incidence, duration, severity, and age at onset of agoraphobia in the wife and her husband's self-esteem.

Hypothesis 3: There are no statistically significant relationships between the incidence, duration, severity, and age at onset of agoraphobia in the wife and her perceived level of individual tension.

Hypothesis 4: There are no statistically significant relationships between the incidence, duration, severity, and age at onset of agoraphobia in the wife and her husband's perceived level of individual tension.

Hypothesis 5: There are no statistically significant relationships between the incidence, duration, severity, and age at onset of agoraphobia in the wife and her education level.

Hypothesis 6: There are no statistically significant relationships between the incidence, duration, severity, and age at onset of agoraphobia in the wife and her husband's education level.

Hypothesis 7: There are no statistically significant relationships between the incidence, duration, severity, and age at onset of agoraphobia in the wife and her employment.

Hypothesis 8: There are no statistically significant relationships between the incidence, duration, severity, and age at onset of agoraphobia in the wife and her perceptions of the family coping stratagems of:

a. Confidence in family problem solving
b. Reframing of family problems
c. Family passivity
d. Church/religious activities
e. Extended family
f. Friends
g. Neighbors
h. Community

Hypothesis 9: There are no statistically significant relationships between the incidence, duration, severity, and age at onset of agoraphobia in the wife and her husband's perceptions of the family coping stratagems of:

a. Confidence in family problem solving
b. Reframing of family problems
c. Family passivity
d. Church/religious activities
e. Extended family
f. Friends
g. Neighbors
h. Community

Hypothesis 10: There are no statistically significant relationships between the incidence, duration, severity, and age at onset of agoraphobia in the wife and her perceptions of the family environment elements of:

a. Confidence in family problem solving
b. Reframing of family problems
c. Family passivity
d. Church/religious activities
e. Extended family
f. Friends
g. Neighbors
h. Community

Hypothesis 11: There are no statistically significant relationships between the incidence and duration of living with an agoraphobic wife and the severity of her illness and the husband's perception of the family environment elements of:

a. Confidence in family problem solving
b. Reframing of family problems
c. Family passivity
d. Church/religious activities
e. Extended family
f. Friends
g. Neighbors
h. Community

CHAPTER II

LITERATURE REVIEW

Historical Perspective

Etymologically, agoraphobia traces its heritage to Greek ancestry and is a derivative of the compound 'agora' (assembly, market-place, open field) and 'phobia' (sense of dread, horror, morbid aversion). Popular usage has tended to translate the malady according to this dictionary definition as "a fear of open places."

Marks (1969) cited the initial usage of the term agoraphobia as occurring in a journal article by Westphal (1871). This first published treatment of the malady identified the symptoms as a fear of market-squares and open fields together and the impossibility of walking through certain streets or (market) squares, or the possibility of so doing only with resultant dread or anxiety.

Further historical clues were provided by Mathews et al. (1981) in their reference to two contemporaries of Westphal, Benedikt (1870), and Cordes (1871). Benedikt (1870) thought the central feature of agoraphobia was dizziness rather than anxiety, and accordingly suggested the name "Platzschwindel" (dizziness in public places), which has not survived. Cordes (1871) made similar observations in his patients -- palpitations, nausea, headache, pressure in the chest, and breathlessness. Mathews et al. (1981) also pointed out that Cordes (1871) noted the fear was often provoked by crowds.

Popular literature tends to present the malady as a fear of open spaces. While in a literal sense this is true, agoraphobia could be more accurately described as a condition in which a person suffers incapacitating fear away from the safety of home, particularly when in crowded or isolated places -- anywhere the sufferer cannot make quick escape or get help quickly should the fears, as imagined, become unmanageable. It may include fear of traveling, especially in a vehicle the agoraphobic subject cannot stop at will (Weekes, 1976)

Beyond the dictionary definition of the illness and Weekes' (1976) broader description encompassing a wide range of applications, personalized definitions are tailored by agoraphobes who tend to define the malady according to their own symptoms. While one agoraphobic may identify it is "the fear of leaving home" another will describe it as "a fear of crowds" (Framptom, 1974). As a result of the idiosyncratic nature of agoraphobia, the literature reflects a varied nomenclature utilized as descriptors: calamity syndrome (Melville, 1977), fear of leaving the safety of the home (Weekes, 1976), phobic anxiety reaction (Klein, 1968), non-specific insecurity fears (Snaith, 1968), street fear (Miller, 1953), and fear of crowds (Frampton, 1974). Hence, simply defining the malady as "fear of open spaces" is inadequate in that it ignores the diffuse fears characteristic of agoraphobia. Suffice it to say, there is no typical agoraphobic.

A General Understanding

Weekes (1976) identified agoraphobia as differing fundamentally and significantly from monosymptomatic phobias such as fears of snakes, fear of heights, or fear of spiders. Agoraphobia is more complex than the

usual phobias. Whereas a specific phobia is monosymptomatic, it harbors fear of a specific situation (e.g. snakes, school, heights, spiders, etc.). Agoraphobia is non-specific and manifests itself in varied symptomatology: one young mother feels safe only in bed, another woman cannot cross the street alone (yet she can drive anywhere); one young man is quite mobile but feels unsafe when driving his auto, especially on the freeways and the problem of one young wife, severely agoraphobic, centers around her fear of being seen (Frampton, 1974).

Agoraphobia, then, stands in contrast to specific phobias in that an acrophobic (fear of heights) can generally avoid such fearful conditions and an aerophobic (fear of flying) can usually arrange the schedule to accommodate other means of transportation. Seldom does a keraunophobic (fear of thunder) with any degree of regularity, experiences an electrical storm. The agoraphobic, on the other hand, is continually made aware of his difficulty in that he contends with his malady every day (Framptom, 1974). Thus, the episodic nature of specific fears stands in contrast to the agoraphobe who lives in constant fear. This distinction is important in that Freud (1962) originally considered agoraphobia to be a specific phobia.

To further complicate a simple definition of the illness, the cluster of phobias or diffuse fears of the agoraphobic syndrome is often accompanied by other non-phobic symptoms such as free-floating anxiety, moderate to severe depression, depersonalization and mild obsessions or compulsions (Marks, 1970). Summarily, the person with a specific phobia is afraid of an object outside himself and he fears it for its own sake -- it's feel, look, potentialities. The agoraphobe, however, fears certain situations but not in quite the same way as specific phobias.

For agoraphobic sufferers, this fear of the feelings that accompany certain situations -- panic, weakness, palpitations -- develops into what has been identified as a "fear of a fear" (Weekes, 1976). The fear of the fear is constant across agoraphobia but the specific situation, event or context evoking this fear is idiosyncratic with the individual. The hallmark of agoraphobia, then, becomes the fear of one's own internal state.

Clinical Features of Agoraphobia

In view of the similarity between agoraphobic syndrome and affective disorders, the question has been raised concerning the reality of the agoraphobic syndrome. Since sometimes containing features of an anxiety neurosis, a phobic neurosis and a depressive neurosis, the issue was broached by Mathews et al. (1982): "Is agoraphobia a discrete syndrome or merely the extreme end of a continuum of fears that are widely distributed in the population?" (p. 9).

Admittedly, a differential diagnosis between social phobia and other disorders has proven difficult, but The Diagnostic and Statistical Manual (American Psychiatric Association, 1980), has provided for a clearer delineation of agoraphobia and defined it as a distinct clinical syndrome. DSM III (American Psychiatric Association, 1980) delineates the essential features of panic disorders (Table I) and agoraphobia (Table II) leading to a separation between phobic disorders and agoraphobia. The episodic nature of the panic attacks stands in contrast to the chronic nature of agoraphobia.

In Mark's (1967) investigation of 72 phobics at the Maudsley Hospital, agoraphobia manifested itself as distinct from other phobias.

TABLE I

DSM III DIAGNOSTIC CRITERIA (300.01, PANIC DISORDER) 1.

A. At least three panic attacks, occurring within a 3-week period and occurring at times other then during marked physical exertion or a life-threatening situation, and in the absence of a physical disorder that could account for the symptoms of the anxiety. Further, these attacks do not occur only upon exposure to a circumscribed phobic stimulus.

B. The panic attacks are manifested by discrete periods of apprehension or fearfulness, with at least four of the following symptoms present during the majority of attacks:

1. Dyspnea
2. Palpitations
3. Chest pain or discomfort
4. Choking or smothering sensations
5. Dizziness, vertigo, or unsteady feelings.
6. Feelings of unreality
7. Paresthesias
8. Hot and cold flashes
9. Sweating
10. Faintness
11. Trembling or shaking
12. Fear of dying, going crazy, or doing something uncontrolled during an attack

C. The panic attacks are not symptomatic of another mental disorder, such as major depressive disorder, somatization disorder, or schizophrenia.

D. Does not meet the criteria for agoraphobia

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1. American Psychiatric Association. (1980). Diagnostic and statistical manual of mental disorders (3rd ed.) Washington, DC: Author.

TABLE II

DSM III DIAGNOSTIC CRITERIA (300.02, AGORAPHOBIA)

A. The individual has marked fear of and thus avoids being alone or in public places from which escape might be difficult or help not available in case of sudden incapacitation, such as crowds, tunnels, bridges, public transportation.

B. There is increasing constriction of normal activities until the fears of avoidance behavior dominate the individual's life.

C. Not due to a major depressive episode, obsessive compulsive disorder, paranoid personality disorder, or schizophrenia.

300.21 Agoraphobia with Panic Attacks

A history of panic attacks whether or not currently present.

300.22 Agoraphobia without Panic Attacks

No history of panic attacks.

1. American Psychiatric Association. (1980). Diagnostic and statistical manual of mental disorders (3rd ed.) Washington, DC: Author.

"There is little doubt from clinical and statistical evidence that agoraphobia is a coherent, clinical syndrome with a well-defined cluster of features which persist together over a long period of time" (Marks, 1969, p. 112). A number of other studies inquiring into the distinct nature of the agoraphobic syndrome (Dixon, de Monchaux, & Sandler, 1957; Hallam & Hafner, 1978; Shapira, Kerr, & Roth, 1979) find a substantial factor loading with agoraphobic symptoms.

The inquiry of Goldstein and Chambless (1978) into the matter of classifying agoraphobics resulted in two distinct types of agoraphobia. They propose a delineation creating for a more precise classification of panic disorders into simple agoraphobia and complex agoraphobia.

Simple agoraphobia

Researchers (Chambless et al. 1978) identified this particular population of agoraphobics as differentiated from other agoraphobics. On the whole, they tend to recover more quickly when any contributing physical disorder is controlled. In these cases, drug experiences and physical disorders such as hypoglycemia, were the precipitants of the panic attack. This category constituted a small percentage of the agoraphobic cases.

Complex agoraphobia.

In the majority of cases, the elements present include:

1. A central "fear of fear."
2. Low levels of self-sufficiency.
3. A tendency to misconstrue the causal antecedents of unpleasant feelings.

4. The onset of symptoms occurring in a climate of notable and generally interpersonal conflict.

For the purposes of this study, the category of complex agoraphobia best described the population under consideration. Agoraphobia as operationally defined for the subjects in this research was: the inability or reluctance to leave home or to enter public places or vehicles, alone or accompanied, because of anxiety or other unpleasant symptoms, or a fear of falling, fainting, or otherwise losing control (Hafner, 1977b). This investigation was confined to those subjects who meet these criteria.

Epidemiology

Agoraphobia, though thought to involve only a small population, has manifested itself recently as a far more prevalent health problem (Mathews et al. 1982). The subject of agoraphobia has made its way into the popular literature of magazines, accompanied by a growing number of phobia clinics. The frequency of this particularly incapacitating malady in the general community has been estimated at 6.3 of every 1000 adult males and females in the United States (Agras, Sylvester, & Oliveau, 1969). Chambless and Goldstein (1982) indicated this may be an underestimation due to the inclination of agoraphobics "to be very secretive about their disorder, resulting in probable under reporting" (p. 3). More recent estimates indicated an occurrence in the population at 1 per 100 (Hardy, 1976). The presence of agoraphobia in the larger community of phobic disorders, occurred as the most common of phobic disorders and represented 60 percent of the phobic patients (Marks, 1969).

The preponderance of females in the known agoraphobic population appeared consistent throughout the literature. Though any patient may become phobic, Frampton (1974) reported 90 percent of phobic patients to be female. Weekes' (1976) survey of 528 agoraphobics reported 91 percent female. Marks (1970) found women to account for two-thirds of the patients treated for agoraphobia. That agoraphobic symptoms predominate in women is challenged by Melville, (1977) as perhaps reflecting sex-role stereotyping: "a woman can suffer from 'nerves' and stay at home but it is not socially acceptable for a man to do so. The men will use a number of strategies to prevent their phobia from crippling their life" (p. 19). Mullaney and Tripett (1979) suggested that males may mask their agoraphobic symptoms with substance abuse. In an investigation of an alcoholic treatment center, Chambless and Goldstein (1982) reported data that seemed to indicate men and women to be roughly equal in the actual frequency of agoraphobia.

Regarding the onset of the intractable malady, Rutter, Tizard, and Whitmore (1968) reported it as very uncommon in childhood and usually beginning in early adult life. Marks (1970) and Mendel and Klein (1969) identified the onset as bimodally distributed, generally occurring between ages 15-20 and 30-40. Generally, agoraphobic symptoms manifest themselves after adolescence but seldom after 40. The onset of the illness appears to be associated with a particularly stressful and anxious period and corresponds with such life stage transitions as childbirth or marriage (Mathews et al. 1981).

The core event at the onset of agoraphobia consists of a spontaneous panic attack which occurs as a highly agitated state (e.g. extreme fear, panic, palpitations, sweating, feelings of unreality and

impending death). From this panic disorder emerges such secondary features of agoraphobia -- anticipatory anxiety and avoidance behavior.

Symptomatology

Panic Attack

There appears to be a uniform appearance of panic attacks at the onset of agoraphobia. These heightened episodes of anxiety "are the most distressing experience complained of by agoraphobic patients" (Marks, 1969, p.252). This state of anxiety is manifested by periods of apprehension or fear and accompanied by at least four of the following somatic symptoms: dyspnea, palpitations, chest pain, choking, dizziness, feelings of unreality, paresthesias, hot and cold flashes, sweating, faintness, trembling, a fear of dying, going crazy, or doing something uncontrolled during an attack (American Psychiatric Association, 1980). Panicking subjects often hyperventilate. These attacks are usually associated with or triggered by environmental stresses in which the subject feels overwhelmed and unable to cope.

Grant, Katon, and Beitman (1983) chronologically arranged the panic disorder into three stages of development. At the outset, the subject experiences, as a result of stressful life events, the overwhelming sense of impending doom or fear of going crazy. The subject may go on to the next stage of associating the attacks with certain events or situations. The fear of having another anxiety attack results in a developing anticipatory anxiety which selectively avoids the feared context or circumstance. In the third stage, the panic disorder incapacitates the sufferer who is afraid of being alone and desperately clings to others for comfort.

Avoidance Behavior

Phobic avoidance develops following the anxiety attacks. This phobia develops from:

> The need to defend oneself against tender impulses or the potential threats against feelings of pride or self-esteem. Loss of control and the attendant humiliating and threatening consequences are aspects of the phobic and obsessive processes...The fear of losing control is in terms of being humiliated and feeling worthless and insignificant because of such weakness. It is the public display of inadequacy and imperfection, rather than violence, which is feared in the loss of control. The phobia, by an absolute injunction, prevents an individual from confronting any situation, place, or person that produces a magnitude of anxiety that threatens to put him temporarily out of control. (Chambless & Goldstein, 1982, p. 21)

Initially, the subject avoids the particular phobic situation since he is sensitized to it and perceives it as threatening. Increasingly, however, phobics tend to globalize their fears and avoid a host of events, associated circumstances and situations lest they, too, precipitate further panic (Marks, 1969). "These avoidance reactions are specific, literal, and devoid of any content other than the anticipated pain or displeasure based on a previous experience" (Chambless & Goldstein, 1982, p.22).

The DSM III indicates five situations most feared and avoided: a) closed or open spaces, b) traveling while alone, c) traveling more than five miles from home by any means, d) walking alone, and e) being alone. It states that the individual must avoid at least one of them in order to meet the diagnostic criteria for agoraphobia. Burns and Thorpe (1977) listed the anxiety-provoking situations most frequently reported by agoraphobic subjects: a) joining a line in a store, b) a definite

appointment, c) feeling trapped at hairdresser, etc., d) increasing distance from home, e) particular places in neighborhood, f) thinking about one's problems, and g) domestic arguments and stress.

Dependency

The DSM III (American Psychiatric Association, 1980) characterized the Submissive-Dependent Personality as an one who relinquishes responsibility for major areas of his or her life. In light of this lack of internal locus-of-control, transfers this responsibility to others.

Andrews (1966) characterized the behavioral disposition of agoraphobics as tending to use avoidance as a method of coping with difficult situations and thus, becomes dependent on others. Other clinical interviews support this finding in their observation of marked dependency problems (e.g. Shafar, 1976). Chambless, and Goldstein (1982) found agoraphobics score lower on self-sufficiency inventories. "Agoraphobics generally feel easier in the presence of a trusted companion...and in some such cases become dependent upon the relative...for their peace of mind" (Marks, 1969, p. 133). The spouse is often the subject of this dependence and the result of the agoraphobic spouse's insufficient self-esteem (Webster, 1953). This lack of confidence may result from the family of origin with the agoraphobic female transferring his or her dependence from the mother to the spouse. Unable to grow in self esteem and confidence, they sought guardians in the husbands (Goodstein & Swift, 1977). In light of this propensity towards dependency, and inasmuch as the fulfillment of the agoraphobics basic needs may depend on the cooperation of immediate

family members, the family environment and interaction becomes a particular concern.

Hypochondriasis

Because of the intensity of the panic experience accompanied by such somatic symptoms: palpitations, chest pains, choking, hot and cold flashes and trembling, agoraphobics characteristically focus on the somatic manifestations. "As a result of the frightening nature of the symptoms a pattern of overutilization of medical care systems frequently ensues" (Grant et al. 1983). Preoccupation with physical symptoms may result in agoraphobic's "routing" their traveling to include close proximity to physician's offices, hospitals, fire stations, minor emergency clinics and health care facilities. This somatization of the anxiety, often results in agoraphobic's exaggerated concern for their physical health. As Chambless and Goldstein (1982) pointed out,

> For many agoraphobics, a headache is not a headache but the symptom of a brain tumor. Consequently, many of these clients frequent emergency rooms and general practitioners offices seeking reassurance. As with social fears, hypochondriasis precedes the onset of phobias for many agoraphobics, where for others the obsessive need for control (which makes taking a new medication terrifying) and doubts about the soundness of their bodies seem to result from their helpless condition and bewildering symptoms. (p. 6)

Etiological Factors

Although the exact cause of this illness is not known, the literature reflected a variety of possibilities including: family of origin, personality predisposition, biological factors, and stress.

Resulting from a 1970's survey, Weekes (1976) listed the most common causes of the malady as reported by the agoraphobics themselves.

In rank order they were: physical illness, stress at home or at work, difficult confinement, a sudden unexpected attack of panic, palpitations or severe weakness while out, depression, and sorrow. Stress was commonly shared by all of these causes. Beyond this subjective realm, however, research was varied in its investigation concerning the etiological factors of this particular malady.

The following is a sampling of the literature speculating about causal factors in the development of agoraphobia.

Family of Origin

Wolpe's (1958) description of an agoraphobic is as follows:

> An only child, during her childhood and adolescence she had been incredibly over-protected by her mother who insisted on standing perpetually in attendance on her. She was permitted to do almost nothing for herself, forbidden to play games lest she get hurt, and even in her final year at high school, was daily escorted over the few hundred yards to and from school by her mother, who carried her school books for her. (p. 4)

From such over-protective environs, the characteristic lack of confidence among agoraphobic subjects is felt to have developed. Thus, in certain circles, agoraphobia has been theorized as a product of dysfunctional parenting. One group of predominantly agoraphobic subjects described their mothers as overprotective more frequently than did an age-matched control group (Solyom, Beck, Solyom, & Huzel, 1974). Regarding the role of maternal overprotectiveness in the development of agoraphobia, Andrews (1966) wrote that the phobia emerged from "early interpersonal (usually familial) learning situations in which the avoidant-dependent patterns is experienced as an adaptive role for the child" (p. 461).

Maternal dominance is considered important in the development of agoraphobia. Yet the research efforts to corroborate the relationship have been less than definitive (Solyom, 1976; Snaith, 1968). Clinical findings noted the prevalence of maternal overprotection in interviews with agoraphobic patients but this was not borne out by a level of statistical significance (Mathews et al., 1981).

Addressing the possibility of being predisposed to phobic behavior by an excitable family context, Hardy (1976) stated:

> If the family is emotional, individual members pick up the emotion and exaggerate or dramatize the associated feelings, which tends to keep the fears alive in the family. Phobias thus can become a part of an area of immaturity that is perpetuated into adult life (p. 21).

Other aspect of the agoraphobic's family of origin may merit searching out as Webster (1953), for example, found that the father of agoraphobics tended to be absent from the home with greater frequency that with other control groups. Snaith (1968) reported a higher incidence of unstable family background among one agoraphobic population. Further inquiry into the family context of agoraphobic, led Buglass, Clarke, Henderson, Krietman, and Presley, (1977) to note a significantly larger number of step parents or adoptive parents within the parental system of agoraphobics. Attempting to seek explanation, the presence of agoraphobia was viewed as a response to behavior in the parental system. While the findings are not conclusive, it appears that the family of origin is relative to the development of agoraphobia.

Biological Factors

The disproportionate number of females within the agoraphobic

population has raised questions concerning the possible role of endocrine fluctuation in the development of the malady (Zitrin, Klein, Lindeman, Tobak, Rock, Kaplan, & Ganz, 1976).

In assessing the susceptibility of women to acquiring a conditioned response in relation to the menstrual cycle, Asso and Beech (1975), and Vila and Beech (1977) reported a vulnerability during the menstrual phase. At first consideration, this seems plausible, especially in light of the onset of agoraphobia during the post partum period. Emmelkamp (1979) indicated that the post partum period may be viewed as a time when a woman is feeling most trapped. However, Mathews et al., (1981), cited Marks (1969) as taking issue with the speculations of hormonal imbalance as "the presence and the nature of a precipitating factor seem to have no obvious relationship to the subsequent course of the disorder" (p. 13).

Further explorations into the etiology of agoraphobia initially led researchers to posit the influence of genetic factors. However, the investigations have generally "concluded that there is no evidence for an increased prevalence of phobic or other psychiatric illness among the parents of agoraphobics" (Mathews et al., 1981, p 33). Marks (1969) concurred that "although phylogenetic influences shape the form of phobias in man as a species, there is no firm evidence that genetic inheritance plays a significant part in the development of phobic states in particular patients" (p. 79).

Stressful Life Events

The sudden onset of the panic attack usually occurs at a time when the patient is under stress of some kind, such as illness of a child,

marital conflict, or some other common family problem (Mathews et al., p. 39). Solyom et al., (1974), identified domestic crises, death of a relative or friend, and serious illness to be evident at the time of the acute episode of anxiety. The DSM III notes that several investigators associate the onset of agoraphobia with sudden object loss.

There is some disagreement as to the value of searching for stressors (Marks, 1970). Yet the role of background stress in the development of the malady is clearly evident in the literature and associated with the onset of agoraphobia (Buglass et al., 1977; Goldstein & Chambless, 1978; Snaith, 1968).

Summarily, the research on the specific etiology of agoraphobia is non-conclusive. It does, however, identify the agoraphobic as experiencing the initial anxiety attack at a period of high stress. Furthermore, the agoraphobic personality may have been predisposed to a state of dependency by maternal overprotection. "There is no evidence that agoraphobia is inherited directly, although traits of fearfulness and anxiety-proneness (which are elevated in agoraphobia) may have a genetic basis (Mathews, et al., 1981).

Treatment Modalities for Agoraphobia

A review of the literature identified the therapeutic community's approach to agoraphobia as utilizing a variety of psychological treatment modalities: (1) psychotherapy, (2) chemotherapy, (3) systematic desensitization in imagination and in vivo.

Psychotherapy

Founded on psychoanalysis, the traditional therapeutic strategy is

essentially a form of treatment attempting to change behavior by providing the patient with insight into the origin and function of the phobia. Sexual desires concerning prostitution, exhibitionism or adultery or repressed aggressive feelings toward parental figures have been suggested as offering explanation for agoraphobic behavior. The literature is consistent in viewing a psychotherapeutic treatment of agoraphobia as inadequate in itself. While conceding the subject's need for a supportive relationship and an encouraging therapeutic environment, there is considerable emphasis on building upon this relationship to persuade the agoraphobic to confront situations that arouse fear (Andrews, 1966). Terhune (1949), writing on the treatment of phobias, remarked that "a process of psychological ventilation, in which the patient discusses his mental conflicts, is seldom itself curative" (p.169). He went on to recommend that phobics be encouraged to risk invading the phobic area (see also, Friedman & Goldstein, 1974; Ey, Bernard, & Brisset, 1974; Tucker, 1956). The necessity to risk anxiety in confronting feared situations has been a pervasive element throughout the literature.

Systematic Desensitization

This active, remedial approach has seen a constant in the literature and mainly consists of two approaches: a) imaginal technique and b) in vivo exposure.

Imaginal methods consist of fear reduction in the subject by constructing a hierarchy of actual feared situations and working or imagining the subject through the situation (Wolpe, 1958). Anxiety is countered with learned relaxation techniques. It is assumed that

repeated exposure to the phobic condition within this mental rehearsal will gradually reduce the anxiety level within the feared context itself. Though systematic desensitization appears effective in the treatment of specific phobias: test anxiety, speech anxiety and snake phobia, it is reported to be much less effective in the treatment of agoraphobics (Emmelkamp, 1979).

In vivo is an exposure method in which gradual and repeated exposure of the subject to the actual feared situation is utilized to orient the sufferer to the realization that the anxiety can be managed and need not debilitate.

Drug Treatment

Since anxiety is the prevalent feature of agoraphobia, anti-anxiety agents have been used to treat the condition. They have been felt to be inferior to tricyclic antidepressants, imipramine and desipramine which have been shown to be effective therapeutic agents in treating the panic disorder (Grant et al., 1983). In conjunction with drug therapy, supportive and behavioral components are indicated to treat the problems of interpersonal difficulties, anticipatory anxiety and avoidance behaviors.

Summary

Among the divergent approaches, Chambless and Goldstein (1982) agreed that a single commonality emerges: "All authors agree that exposure is an important part of treatment, but they vary in the degree to which it is emphasized and in the way it is conducted" (p. 215). Predicated on a sympathetic and encouraging therapeutic environment,

treatment of agoraphobia may then proceed to include a confrontation of the anxiety, uncertainty, and discomfort of the malady.

In contrast to specific phobias, most agoraphobics have other problems in addition to the phobia, including free-floating anxiety, panic attacks, and depression (Chambless & Goldstein, 1982). In view of the multiple problems and secondary manifestation accompanying agoraphobia, Holm (1982) recommended a blending of treatment modalities: 1) individual, dynamically oriented psychotherapy; 2) exposure treatment; and 3) psychopharmacological treatment.

Family As System

Systems Theory

Since the end of the 19th century, there has been a gradual movement away from the traditional one-to-one to model of viewing illness within a family member, towards a more integrated approach. Implied within Systems Theory is a paradigmatic shift from linear presuppositions to a restructuring of the family specialist's thoughts patterns. Within this framework, the family becomes the basic system for analysis, research and treatment (Kaslow, 1982).

System Theory's challenge to the linear causality of traditional scientific methodology is to guard against the micro-analytic approach which infers that the total phenomenon can be understood by analysis of the individual units. Such reductionism, breaks down family phenomena into separate parts on the assumption that the whole is equal to the sum of its parts. At the base of Systems Theory lies the concept of non-summativity which says, in effect, that the effects of system membership on individual or system behavior are greater than a simple

summation of the behavioral characteristics of the individuals within the system. This cybernation of Systems, has resulted in a more holistic, synergistic approach to family, shifting attention from characteristics of the individual member to interactions and interrelatedness within the family system.

Okun and Rappaport (1980) trace the application of systemic concepts to families through: a) the 1908 classic case of Freud's (1964) treatment of little Hans, b) the development of the Child Guidance Movement, c) the understanding and treatment of schizophrenia, and d) the beginning of family therapy. The significance of these events to family and family therapy is such that it merits brief consideration.

In the case of little Hans, Freud (1964) made frequent reference to the boy's family. The interpersonal, transactional nature of the phenomenon was such that their anxieties and admonitions were felt to have affected their son.

The Child Guidance Movement began in 1909 with the creation of the juvenile court to treat delinquent children considered disturbed. It was realized that treating the child alone was insufficient as much of the delinquent behavior appeared to be the product of family relationships. Consequently, the mother and the father were introduced into the rehabilitation of the child.

Understanding and treatment of schizophrenia, historically, revolved around a purely individual, intrapsychic theory. The need became apparent to include relations as part of the therapeutic process and to solicit their assistance in the remediation process. From this posture, therapists moved to treat both the schizophrenic patient and

the family as a unit.

The beginning of family therapy in 1950 must not be overlooked. In chronicling the move towards understanding family processes as critical to understanding family members, Ackerman and Sobel's (1950) article "Family Diagnosis: An Approach to the Pre-School Child" appeared in the American Journal of Orthopsychiatry signaling another step in the direction of family therapy. To this, add the contributions of Reusch and Bateson (1951) and Bateson, Haley and Weakland (1956) regarding communication networks.

Summarily, Jackson (1951) identified the impact of a systems mentality when he stated that:

> We are on the edge of a new era in psychiatry and the related disciplines of psychology, social work, anthropology and sociology. In this new era we will come to look at human nature in a much more complex way than ever before. From this threshold the view is not of the individual in vitro but of the small or larger group within which any particular individual's behavior is adaptive. We will move from individual assessment of analysis to contexts, or more precisely, the system, from which individual conduct is inseparable. (p. 139)

Family Response to Chronic Illness

Agoraphobia manifests itself to the ill subject through obvious social and emotional limitations. At a less visible level and, perhaps, in a more subtle manner, the malady seriously effects the structure and interaction processes of the immediate family network. These secondary implications prove a serious disruption for marital and family functioning. In an attempt to foster greater understanding of chronic illness within family systems the following survey of literature is presented on family response to chronic illness.

Dependency. In response and adaptation to chronic illness, the protracted nature of the malady creates a fertile sphere for the development of ill-subject dependency (Blacher, 1970; Lederer, 1952). The patient is inevitably placed in a dependent position which causes him to feel childlike and helpless. Initial reaction to such dependence may be that of resentment and shame. If the illness continues and proves too overwhelming, the ill subject may become clinging as a result of losing his sense of self-sufficiency (Schoenberg & Senescu, 1970). An investigation into the factor of independence, led Vignos, Thompson, and Katz (1972), to report that the adjustment of an arthritic patient within the family context may depend on the autonomy of the ill subject to perform the routine activities of daily living. Continued dependence of the ill subject upon other members of the family may have an adverse effect on relationships with family members. Such dependency may reflect a genuine inability to function at the previous level of operation or it may signify an unconscious preference for being taken care of over being independent (Abram, 1972). Chodoff (1962) found among disabled and crippled multiple sclerotic patients a sense of ambivalence towards dependence, a conscious rejection coupled with an unconscious longing for it

Conception of the Illness. Accretion of knowledge and accurate perceptions within the family system regarding the malady is likely to have a significant impact on the sick member's response to the illness and the family's response to the sick member. Inappropriate responses and misunderstandings among family members regarding the behavior of the ill member may be the product of insufficient information or inadequate education concerning the particular malady suffered by the ill member.

Overs and Healy (1973) concluded in their study of stroke victims that stroke families were not adequately informed concerning strokes and the effects which might be expected.

In a study of randomly selected applicants for disability benefits, Zahn's (1973) findings supported the conclusion that an illness or disability whose impairments clearly indicated impairment tended to be associated with better interpersonal relationships. An illness, clearly defined as such, seemed to legitimize the sick role. However, when the health of the individual seemed to be in doubt, problems in the interpersonal relationships seemed to occur.

Chronic Illness and the Spouse. Klein, Dean, and Bogdonoff (1967), in their study of 121 chronically ill subjects, inquired into the effect of illness upon the identified subject's spouse. Data indicated a marked change in levels of interpersonal strain. The scores of both partners during the illness reflected the perceived increase in interpersonal conflict and frustration.

In a study of 33 families in which the ill subject was the husband, Clausen & Yarrow (1955), examined the kind and intensity of symptomatic behavior. They identified several elements which played a role not only in the formation of the wife's perception of mental illness, but also in her adjustment to the husband's illness. These elements included: the malady's persistence over time, the husband's interpretation of his illness, the wife's conception of the nature of emotional illness and her tolerance for emotional disturbance.

The literature is consistent in suggesting that, to maximize the ill subject's rehabilitation, the involvement and support of family members is vital. Schoenberg and Senescu (1970) cautioned, however,

that caring for the ill family member often necessitates providing relief from responsibilities. If the family member compensating for the ill subject's inability to fulfill role responsibilities is not himself provided with an opportunity for some role relief, he may become as sick as the patient.

Recovery and the Family. Illness of a family member does not occur within a vacuum and optimal rehabilitative efforts cannot ignore the family network. A recent study attempting to develop a measure of social support (Burge & Figley, 1982), found that, among a diverse group of people, family members were named most often as those to whom one would turn in times of need. They were cited as providing emotional support, encouragement, advice, companionship, and tangible aid. Thus, Hirsch (1980) identified family members as critical to victims of sudden, unexpected, life-threatening illnesses or experiences. Rapoport & Rosow (1966) suggested there was reason to believe that "a patient's family relationships may be a more significant condition of and limitation on successful rehabilitation than whatever influences occur for long term, intensive, individual psychotherapy" (p. 231). Reaffirming the important role of family members to the ill subject's recovery, Kong-Ming New (1968) maintains that there is little doubt that a patient's eventual satisfactory adjustment to a crippling, chronic disability depends on a supportive family network. Though understanding and supportive of the ill subject, family members are encouraged by the authors to support the patient's independent functioning in daily routines. Fostering autonomy and independence contribute to the ill subject's rehabilitation.

While indicated for rehabilitation, nurturing and supportive family

networks are not always the case among the chronically ill. Christopherson (1968) reported that a family may become a non-therapeutic community via skepticism, over-protectiveness, unsympathetic and even hostility of family members. Schoenberg & Carr (1970) concur that frequently the progress realized by hospitals and medical professionals is frequently lost when the patient returns home if the family members are not prepared to cope with the disability.

It has been observed that family attitudes are critical to rehabilitation. The involvement of the family in a supportive and constructive fashion, then, is imperative to the design of a therapeutic family network. To operationalize the concepts of family support and participation in recovery, Christopherson (1968) proffered the suggestion of a counseling milieu directed to changes in family roles consistent with the changed physical and mental abilities of the ill subject.

Reflection on this review of literature indicates the important therapeutic role the family plays in rehabilitation. Establishing informed, supportive family relationships can be an important step in fostering recovery and minimizing exacerbation of family complications in chronic illness.

From the aforementioned studies, inferences may be drawn regarding an appropriate treatment of agoraphobic families. The chronic and acute nature of the illness with its restrictive component creates for profound disruption in family functioning. Foundational to the subject's recovery and the family's adjustment is the spouses' understanding of agoraphobia and the recognition of tolerance required. Consequently, in agoraphobic treatment, merely diagnosing the malady and

focusing on the illness, per se, may be inadequate. Rehabilitative modalities could include family intervention regarding family conception of the problem and family expectations of the ill member.

Family Response to Emotional Illness. Interaction with agoraphobic families and pursuit of the available literature, revealed a common thread woven throughout the fabric of the disorder -- the adjustment of family members to the psychological structure of its agoraphobic member. The bulk of the literature, however, seems disproportionately weighted towards the nature and treatment of the illness. Information on the family's relation to the illness has been meager. It is surprising that the investigators provide ample documentation on the career of the agoraphobic but neglect the corresponding career of the agoraphobic's family and their possible role in the outcome of the disorder.

Haley (1982) indicated that family therapists are increasingly focusing attention upon the ill subject's family system. This wide-angle lens approach stands in bold contrast to the ill-subject locus of attention generated by the psychoanalytic approach, to mental health. This change of perspective incorporates an analysis of the context of the illness, versus the microscopic focus on the ill subject, per se.

In a review of the literature pertinent to family response to the mental illness of a relative, Kriesman, and Joy (1974) identified three major components: (a) the family's definition of the illness, (b) the family's attitude toward its ill member, and (c) the effects of attitudes of family members on outcome. The following elaboration of these three areas relies heavily upon the Kriesman and Joy (1974)

effort.

The Family's Definition of the Illness. Figley & McCubbin (1983) identify the period of time subsequent to illness or crisis as when the victims attempt to cognitively master the problem or crisis by answering the fundamental question of, "What happened to me?" And following the illness or catastrophe, subjects typically ruminate about the events which entrapped them and search for the answer. This quest for a label is not the province of the ill subject alone; members of the subject's family system seek a label for the illness. The matter of definition is significant to the family's adjustment to the illness and particularly in illness of the emotional or mental genre, where family members are left to explain the deviant behavior of their ill family member to relatives and friends. The matter of definition, then, becomes significant to the family's adjustment to the illness. The task is further complicated in view of the tendency of the general public to attach a negative connotation towards the mentally ill (Rabkin, 1972).

In the Yarrow, Schwartz, Murphy, and Deasy (1955) study of mentally illness, the spouses experienced several phases of changing perceptions before identifying the problem as mental illness. The initial phase denied mental illness as the problem and a psychiatric diagnosis was accepted only after a threshold for tolerance had been reached. Family members tended to identify the ill member's behavior in terms of character weakness, physical ailments, or situational factors.

In a replication of Yarrow, Clausen, and Robbins, (1955) classic study into the meaning of mental illness in the family, Warren (1983), inquired into the general experiences of spouses in dealing with familial mental illness. Multiple interviews were conducted by a team

of interviewers with 17 schizophrenic women and 16 of their husbands over a period of two years starting the week of hospitalization and continuing well into the discharge period with the mean number of interviews for each case being fifty. The husbands' initial interpretations of the wives' problems centered around gender explanations: menstruation, menopause, childbirth and child loss. Whereas women are more likely to monitor others behavior, a number of the husbands did not notice up to the day of hospitalization that anything was wrong with their wives. Both husbands and wives tended to assign their spouses problem to the benign realm of physical ailments, the stress of circumstances, personality traits, etc. rather than identify it in psychiatric terms.

The husbands' feelings for their wives seemed to be a determinant in the initial interpretation of the illness. Those husbands who said they loved their wives and wanted to continue the marriage seemed less willing to give up normal definitions. Rose (1959) and Mills (1962) found that the closer the family ties, the greater the reluctance to perceive mental illness. However, Clausen's (1959) investigation into the spouses of 23 schizophrenics found that when the spouses became the target of the symptomatic behavior, an interpretation of deviance was more readily accepted. The Safilios-Rothschild (1968) replication of the Clausen (1959) research confirmed the findings. Formation of definitions regarding emotional illness are slow in coming because the symptoms were not likely to be recognized by family members and the deviant behavior was recognized as a function of character weakness, physical ailment or situational factors. Even when the husbands in the Yarrow, Schwartz, Murphy, and Deasy (1955) study were diagnosed as

psychotic and to be hospitalized, 20 percent of the wives still denied their husbands were mentally ill. Lewis & Zeichner (1960) found in a sample of 109 families at three Connecticut State hospitals that 18 percent of the families denied the patient's mental illness and in 40 percent of the cases, the problem was first recognized by a physician or someone outside the family.

Family Attitude and Response to its Ill Member. Recurring episodes of deviant behavior, diagnosis of mental illness and possible hospitalization led most families to accept their ill member as mentally ill. Family reaction at this point may run the gamut from a sympathetic response with increased support to a diametrical intolerance. Anthony (1969) after reviewing the literature formulated a framework for understanding the wide range of family responses to illness: illness as trouble: illness viewed as deviant behavior: illness as a disruption of complementary family roles, and illness as a crisis in accommodation.

Regarding illness viewed as trouble, Koos' (1946) study of low-income family response to stark emergencies uncovered illness referred to generally as "trouble." For example, an ill mother disrupted family housekeeping so the home became dishevelled and an ill father resulted in lost resources and reduced family income. In short, the ill member created hardship, emotionally and financially for the rest of the family.

Considering the deviant behavior of illness as a possible escape from life's problems, Parsons and Fox (1952) developed the view that illness, may be the patient's attempt to divest self of life's problems. In this context, illness becomes a "solution" to life's difficulties. Though burdening the rest of the family, the ill member desperately

seeks respite from life's pressures via a sick routine.

Spiegel (1957) portrayed illness as a disruptive force in the understanding and functioning of existing family roles. Deviant behavior of the ill subject requires an adjustment in the family in which family roles must shift to accommodate the behavior or deficiencies of the sick member. Although, confusion, misunderstanding, and sometimes role reversal disrupt the complementary role patterns, the family may adapt to a newer and healthier family system.

Regarding illness as a crisis in accommodation, Burge and Figley, (1982), in a study of returning veterans, noted that "the ease with which the family structure can undertake the realignment of roles during the recovery phase of the trauma will affect the amount of conflict experienced in their daily interactions " (p. 16). A major effect of an ill member's distress is to create a need to change alignment of the roles of family members (Hill & Hansen, 1962). As a result of an illness or trauma, the individual may be unable to perform certain tasks or even interact with others as before the onset of the illness. The amount of accommodation and relative ease of the family member's realignment will be proportionate to their tolerance for deviance and likewise affect the amount of conflict experienced in their daily interactions (Figley & McCubbin, 1983).

Dysfunctional coping of a family network with subsequent aversive reactions towards the ill member appear to be the product of mitigating factors involving both intimacy (Goffman, 1963), and family definition (Figley & McCubbin, 1983). A family definition viewing the situation as a family problem, rather than the problem of one of its members, may enhance family cohesion and intimacy. In the absence of affective

regard and minimal family interaction, the tendency is to stigmatize the ill member and discriminate perhaps to the point of rejection. The more intimate the relationship between the stigmatized ill subject and the other family members, the less the stigma appears to define the person. Thus, closeness permits one to see qualities other than the flaw. Family members have a choice between either embracing the malady of the stigmatized person, and identifying with him, or reject the ill family member by avoidance or perhaps, even terminating the relationship.

Family attitudes towards an emotionally ill member covers a wide range of affective response. Investigating the spouses of mentally disoriented, Schwartz (1956) and Clausen (1959) reported significant amounts of anger and resentment towards the ill member. Yarrow (1955) found that wives not only experienced anger but expressed it as a means to control their husband's behavior. Investigating the spouses of mentally disoriented, Schwartz (1956), and Clausen (1959) reported significant amounts of anger and resentment towards the ill member.

Waters and Northover (1965) reported on wives as being frightened of their long-term schizophrenic husbands after they were discharged from the hospital. Accompanying this fear were lengthy periods of interfamily tension.

Lewis and Zeichner's (1960) study reflected this with 50 percent of their subjects expressing sympathy towards the patient and 17 percent expressing hostility or fear. Rose (1959) found insignificant amounts of negative emotions associated with the feelings of family members. Generally, however, families report little fear, shame, anger or guilt.

Effects of Attitudes on Outcome. Coping with a chronically ill family member and especially one with an emotional illness, incurs

several hardships and becomes a source of stress for the family. In the case of ex-patients, the introduction of the patient back into the family system, disrupts family activities and routines, causes stress and drains the family income (Grad & Sainsbury, 1963; Hoenig & Hamilton, 1969; Arey & Warheit, 1980). The adjustment during the postpatient phase of an emotionally disturbed person is a partial function of the relative's attitudes toward the patient. While some families provide invaluable assistance to the reorientation and re-entry of the ill family member, other families may be so negative as to drive the patient back into the hospital (Stoneall, 1983). Carstairs (1959) reported the significance of a "key person" (a woman willing to involve herself with the patient) with a positive attitude to an ex-patients success in remaining unhospitalized. Likewise, Barrett, Kuriansky, and Gurland (1972) identified family attitudes as significant factors in the outcome.

Generally, the family environment of the emotionally ill member has been hypothesized as related to the success or outcome of the discharged patient. However, Stoneall (1983) is careful to indicate that while all these studies examine family interactions in the postpatient phase, little consideration is given to the viewpoint of the mentally ill person and even fewer deal with the mutual influence between former patients and their families. This echoes Kriesman & Joy's (1974) concern over the omission of the patients from the studies: "patient attitudes, their consequences for family attitudes, and patient behavior are equally important, and have too often been ignored" (p. 50).

In summary, the family is fundamentally changed by chronic illness. In the case of agoraphobia, though few guidelines exist for agoraphobic

families, the literature ostensibly provides a perspective for both the understanding and treatment of agoraphobic families. From the literature, one may surmise that outright denial may be the initial response, followed by definitions attributing the problem to a variety of situational or physiological factors. The complexion of this initial response will probably be more of a non-psychological definition. With this delayed recognition, family members may not arrive at a psychological definition until well into the illness. In the absence of correctly understanding the problem of the ill member, misunderstanding may emerge, regarding both the illness and the ill subject. Though the data are inconclusive, research on the relationship of family attitudes to outcome assumes the importance of such attitudes.

CHAPTER III

PROCEDURE

Subsequent to the review of appropriate literature related to agoraphobia, related syndromes, and the impact of the chronically ill upon the family, certain avenues seem evident to facilitate this inquiry into the family environment and marital dynamics of the agoraphobic sufferer. The initial step towards understanding the behaviors of spousal and family members in families containing an agoraphobic member was pursued through exploratory and unstructured interviews. Distilled from the interviews of agoraphobic couples, four miniature case studies or scenarios emerged. These scenarios avoided the exotic and portrayed typical agoraphobic behavior in the form of episodes which are confronted regularly, often daily, by agoraphobic families.

Due to the nature of the guiding research questions, three populations were incorporated into the research project: a) agoraphobic women, b) non-agoraphobic husbands of agoraphobic wives, and c) a non-agoraphobic (or control) population. To gather information on these three populations, a detailed questionnaire was sent to a group of agoraphobic couples and a control group of non-agoraphobic couples based on the seven initial interviews and the extant literature dealing with the malady. Basically, then, two broad methodologies were pursued: qualitative interviews and subsequent quantitative surveys. Each will be discussed in turn.

Qualitative Procedures

With the available literature clear in its implication of the agoraphobic malady as chronically disruptive and sometimes destructive of the family/spousal system, further exploration of the family coping with agoraphobia is sparse. Consequently, questions still emerge. Though the available research reviewed generally described reactions to agoraphobia, it failed to tap family behaviors which influence the agoraphobic member. Although from the studies investigated significant others have been recognized as critical to adjustment of the malady, the role of family members remains somewhat vague and undetermined.

An exploratory device was needed to guide the remaining phases of the research. This identification of needed-information led to the consideration of the unstructured interview technique as an avenue towards appropriate questionnaire design and definitive areas for investigative pursuit.

The particular research problem and the nature of the information sought must, in the last analysis, dictate whether or not the interview will be used. (Kerlinger, 1973). Interview technique, specifically unstructured interview, was indicated as an exploratory device and to help guide the remaining phases of the research.

Central to the qualitative component of this inquiry was a method designed to capture the subtle emotional and familial nuances within agoraphobic families -- a free expression of the manner in which agoraphobia has impacted the lives, thoughts and feelings of the subjects and other family members; their perception of the ill member; their understanding and definition of agoraphobia; coping strategems the family has utilized and the emotional milieu surrounding the illness and

the family network. Selltiz et al. (1959) identified the interview as the more appropriate technique for revealing information about complex, emotion-laden subjects or for probing the sentiments that may underlie an expressed opinion. If a verbal report is to be accepted at face value, it must be elicited in circumstances that encourage the greatest possible freedom and honesty of expression. Thus, the unstructured interview was settled on as likely to be more successful in creating an atmosphere that not only allowed the respondent's reporting behaviors that are customarily disapproved but actually fostering the subject's expression of feelings.

Broadly speaking, the unstructured interview is a face-to-face interpersonal role situation in which one person, the interviewer, asks a person being interviewed, the respondent, questions designed to elicit information pertinent to the research problem (Kerlinger, 1973). Governed by the research purposes, the unstructured interview is an open situation which, though guided by the interviewer, allows the respondent freedom to express his/her own particular thoughts. The unstructured interview technique consisted of several components including:

1. Subjects for the Interviews
2. Content of the Interview
3. Interview procedures, per se
    a) Time and Duration of Interviews
    b) Context and Atmosphere
    c) Retention and Retrieval of the Interview

Subjects for the Interviews

Because of the relatively small available population of

agoraphobics and the tenuousness sometimes existing in both agoraphobics and their families, only a small number of families participated. From the known agoraphobic population in the Tulsa metroplex, seven particular families were initially recommended by a clinical psychological specialist in agoraphobia for participation in this study. A final evaluation by the psychologist eliminated three of the families -- deeming their participation as unadvisable due to suicidal tendencies of one subject and potential divorce in the two remaining families. The remaining four families consisted of an ill subject and his or her non-agoraphobic spouse.

All the families lived within the Tulsa metroplex. This distance was determined considering the difficulty some agoraphobics experience in mobility, as well as allowing time flexibility for each visit. The families were substantially intact family systems with the husband and wife residing together at home.

Marks (1970) and Terhune (1949) report that about two-thirds of agoraphobic patients are women. Weekes (1976) research identified 91% of her agoraphobic subjects as women. Though not by research design, the sex differences in the subjects participating in the in-depth interviews approximate the incidence of agoraphobia in the literature with 3 out of the 4 being female.

Content of the Interviews

The specific focus of the give-and-take-dialogue between the researcher and respondent was the attitudes and behaviors of family members, including the agoraphobe, as they related to each other and to the malady. Investigated were the family definitions of the problem,

family roles, the family's attitudes toward the agoraphobic member, the family's affective response, the effects of family member's attitudes and the family's tolerance of agoraphobic behavior.

Interview Procedures

The interviewers were conducted using standard conventions for interview methodology as discussed in the literature. The subjects were initially contacted by the clinical psychologist who elicited their participation in this research project. The researcher then telephoned each couple to confirm their willingness to participate in the project.

All seven interviews were conducted by the researcher, himself. Each interview was conducted privately and independently of the spouse. A minimum of 15 minutes was taken at the outset of each session to inform the respondents of the nature of the project in order to allay any anxiety or discomfort. The researcher expressed gratitude for their willingness to share intimate and emotionally laden aspects of the agoraphobia and its impact on the marriage. Care was taken to inform the respondents, both visually and verbally, of the presence and utilization of the tape-recorder. Subjects were told that the interviews would be transcribed into verbatim dialogues for inclusion in the dissertation (anonymity was guaranteed). At the point at which the investigator judged that adequate rapport had been established and the respondent was comfortable, the tape-recorder was turned on.

Time and Duration of Interviews. To minimize inconvenience, scheduling of the interview was left to the discretion of the subject. In view of the issue of "subject fatigue," duration of the interview session was initially set for 45 minutes. However, the willingness of

the subjects to converse freely, coupled with a seemingly intense desire to share both agoraphobic experiences and expression of feelings caused the researcher to re-evaluate the length of the interviews. In view of such uninhibited and free expression, the duration of the sessions was 60 to 90 minutes, depending upon the interactive process of the particular session.

Context and Atmosphere. Given the importance of a friendly atmosphere to put the respondent at ease a primary consideration was the context in which the interview sessions would occur -- a context conducive to verbal interaction with minimal distraction. Initially, the natural setting of the subject's own home seemed an appropriate location, considering the characteristic reluctance of most agoraphobics to travel far from home. Yet the distractions of the respondent's own home were felt to be contrary to the requirements of a comfortable milieu in which the subject would feel free to voice frank opinions without fearing breach of confidentiality or violation of privacy during the interview. During the interview session, the researcher would adopt a non-judgmental stance to maximize the comfort and openness of the respondent, but the interview would be carried out away from the respondent's own home.

The location for the interview session was the regular meeting place for the Agoraphobic Recovery Seminar. Consequently, each of the subjects, having frequented this building previously, brought with them a familiarity of both the location and the structure itself. It was felt that familiarity with this particular site would serve to minimize respondent discomfort by not compounding characteristic agoraphobic reluctance to travel from home to unfamiliar territory.

Retention and Retrieval of the Interviews. Tape recording allowed the investigator to concentrate on the interview without distracting the respondent (or himself) by taking notes and still retain all the verbal input of the subject. One of the essential characteristics of the unstructured interview is the detail obtainable; the respondent can be allowed to talk until he exhausts a particular topic or a particular feeling (Forcese & Richer, 1973). To anchor the session within a framework of candor, the interviewer was careful to bring attention to the tape recorder, simultaneously pointing out that the session would be transcribed to manuscript form but names would not be recorded in the corpus of the research text. The actual recording did not begin until: a) Completion of the social amenities; b) The interviewer discussed the purpose of the project and; c) The respondent appeared to be relatively comfortable within the interview setting.

Of the four families participating in the in-depth interviews, each subject was interviewed independently of the spouse. The interview verbatims (Appendices F to I) are the result of eight, 90 minute, one-time interviews.

Quantitative Procedures

The interview mode of data collection served as the initial step for the descriptive investigations of the agoraphobic couples. To corroborate the data generated in the interviews, a questionnaire methodology was employed. Predicated on the interviews, and the areas of concern expressed by agoraphobic families, appropriate research instruments were selected to facilitate the investigation and were mailed to agoraphobic couples and a non-agoraphobic control group. The

questionnaires provided additional information on each family member and were intended to increase an understanding of agoraphobic families.

The Pilot Study

In order to evaluate the instrument and test the efficiency of the data collection procedures, two pilot samples were selected. The first utilized a Tulsa, Oklahoma, singles group (n = 22) which was expected to approximate the mean age and background anticipated for the agoraphobic sample. The emphasis of this piloting effort was to test the agoraphobia scenarios drawn from the qualitative interviews already conducted. This pilot instrument (see Appendix D) comprised six agoraphobic case studies and elicited open-ended responses.

Based on these pilot responses, forced choices were assigned to each scenario (see Appendix D) and administered to 65 students enrolled in a service course on marriage and the family offered at Oklahoma State University. The crux of the second pilot (see Appendix E) was to determine the amount of time required for completion of the questionnaire as well as test the clarity and efficiency of the scenario responses and the other quantitative scales.

All pilot subjects were encouraged to react to the form and content of the instrument following their completion of the questions. As a result of the two pilot tests, few changes were made in the form and content of the final instrument (see Appendix A).

Subjects for the Survey

Agoraphobic Couples. Thirty-five agoraphobic females responded to the questionnaire from March through May, 1984. Subjects came from two

data collection points: the Dallas -- Ft. Worth Metroplex and the greater Tulsa, Oklahoma area.

Of the 60 sets of questionnaires distributed at the Texas site, the 13 responses collected reflect a 21.6% return. Of the 48 agoraphobic families surveyed in Tulsa, Oklahoma, 22 elected to participate in the study, reflecting a 52% response rate. Thus, the overall response rate for agoraphobic families was 35.2%. (As will be evident in subsequent tables, the surveys netted 8 non-compliant male spouses. Because of the relatively small number of respondents, the non-compliant spouses were assigned missing value status.)

The Control Group. The control sample of 96 non-agoraphobic individuals was drawn from parents with children enrolled in Oklahoma State University's Child Development Laboratory and parents with children enrolled in a Tulsa pre-school. It was felt that this group approximated the geographical and demographic characteristics expected of the agoraphobics and their husbands and would allow some discrimination between attitudes and family environment of the agoraphobic home and family life in the general population.

The control sample in Tulsa resulted in a 31.7% response rate (n = 27). The control sample from the OSU Child Development Laboratory in Stillwater, Oklahoma, resulted in a 28% participation of the families surveyed (n = 21).

Instrumentation

Distillations from the qualitative interviews served as the basis for brief scenarios which were included in the questionnaire. The scenarios generated by the interviews were combined with other

inventories deemed consistent with the research design: the Rosenberg Self-esteem Scale (1965), the Semantic Differential (Osgood, 1957), the Family Environment Scales (Moos & Moos, 1981), and the Family Coping Strategies (McCubbin, Larsen, & Olson, 1982). Concluding the instrument were a series of demographic questions as well as questions related to the presence and manifestation of agoraphobia.

Agoraphobia Scenarios. In their guidelines for questionnaire construction, Selltiz et al., (1959) indicate the imperative of respondents possessing adequate information to answer the questions. Generally speaking, agoraphobia will not fall within the range of most of the respondent's experience. Thus, the design of this segment of the questionnaire had to take into consideration this general naivete regarding agoraphobic symptomology. Inherent within instrument design was the necessity of providing descriptive information to the respondents in the course of the instrument.

In view of these limitations, case studies were utilized to measure the sample population's attitudes and reactions to agoraphobic behavior. These case studies or scenarios are representative of the symptomology characteristic of the agoraphobic malady and will provide a projective technique involving the presentation of the stimulus situation for the purpose of tapping specific attitudes toward agoraphobic behavior. Vis-a-vis these scenarios, the non-agoraphobic population are confronted with agoraphobic behavior to which they can respond.

Such a projective technique, for the agoraphobic respondents, is designed to provide a measure of distance from the sufferer's own personal situation to which he/she can ostensibly respond impersonally. The vignettes occasionally take the form of asking about "other

people's" attitudes and actions. The assumption here is that a respondent may hesitate to express critical views of his own, but will put them -- project them -- into the mouths of other people (Selltiz et al., 1959).

Essentially, the scenarios served as a means of ascertaining attitudes towards agoraphobia, per se. By presenting a variety of situational contexts characteristic of the agoraphobic sufferer, data were elicited concerning both agoraphobic sufferers and members of agoraphobic families regarding: reactions to agoraphobic behavior; recommended coping strategems for agoraphobic families; the perceived impact of agoraphobia upon family members; the future of a marital relationship in which one spouse is agoraphobic.

The agoraphobic case study portion of the questionnaire consisted of four situational contexts to which non-agoraphobic spouses or family members confront with regularity. These scenarios of agoraphobic behavior are actual cases derived from the literature and from interviewing agoraphobic families.

Semantic Differential. The semantic differential was selected for use in this study because it permits the tapping of concepts of the illness and the impact of the agoraphobia on the family. The subject is provided with a concept to be differentiated and a set of bipolar adjectival scales against which to do it.

In constructing the semantic differentials, the bipolar adjectives were selected from Osgood's (1957) thesaurus of bipolar adjectives. The adjectives were chosen by the researcher as relevant to the concept to be assessed, e.g. the effect of the illness (agoraphobia) on family members. The bipolar adjectives are used on a seven point rating scale.

Self-esteem. Because of the debilitating nature of agoraphobia, it was judged essential to measure respondent's self-esteem. While the semantic differential is taken as a measure of self-evaluation, the Rosenberg (1965) Scale asks more direct questions vis-a-vis individual perceptions of worth and value. In addition, the scale is readily understandable and brief. Consequently, it was included in the final questionnaire (see Appendix A).

Family Environment Scale. Family Environment Scale (FES) is the designation used by Rudolf H. Moos (Moos & Moos, 1981) to describe a 90-item instrument designed to assess the climate within a family structure. This instrument was developed at the Social Ecology Laboratory, Department of Psychiatry and Behavioral Sciences, Stanford University, and the Veterans Administration Medical Center, Palo Alto, California.

The Family Environment Scale focuses on the measurement and description of the interpersonal relationships among family members, on the directions of personal growth which are emphasized in the family, and on the basic organizational structure of the family (Moos & Moos, 1981). It is comprised of ten subscales that measure the social-environmental characteristics of all types of families. These subscales assess three dimensions of family life: the Relationship Dimensions; Personal Growth Dimensions and System Maintenance Dimensions.

Table III enumerates the subscale containing the Relationship dimensions conceptualized as Cohesion, Expressiveness, and Conflict. Moos and Moos (1981) identifies these subscales as assessing the extent to which family members feel that they belong to and are proud of their

TABLE III

FES RELATIONSHIP SUBSCALES DESCRIPTIONS

Subscale	Relationship Dimensions
1. Cohesion	The degree of commitment, help and support family members provide for one another
2. Expressiveness	The extent to which family members are encouraged to act openly and to express their feelings directly
3. Conflict	The amount of openly expressed anger, aggression, and conflict among family members

family; the degree of commitment, help and support family members provide for one another; the extent to which there is expression within the family and family members are encouraged to act openly and freely express their feeling; and the degree to which anger is readily expressed and such conflictual interactions are characteristic of a particular family system.

Table IV depicts the second group of subscales conceptualized as Personal Development or Personal Growth Dimensions. They are intended to measure the emphasis within the family on certain processes which may be fostered by family living: Achievement-Orientation, Intellectual-Cultural Orientation, Active-Recreational Orientation, and Moral-Religious Emphasis. These subscales measure the family's emphasis on autonomy of individual family members and the degree to which family members are assertive, self-sufficient and make their own decisions. The emphasis on the degree to which competitiveness might be superimposed over both academics and other activities and such involvements characterized within an achievement framework. Other dimensions and emphases which might be significant to individual and family growth -- recreational, religious, political and cultural participation -- also fall within the concerns of the Personal Growth dimension.

The last two subscales of Organization and Control are identified as assessing System Maintenance dimensions. These subscales are system oriented in that they concern themselves with the degree of importance of clear organization and structure in planning family activities and responsibilities and the extent to which set rules and procedures are used to run family life (Moos & Moos, 1981).

TABLE IV

FES PERSONAL GROWTH SUBSCALES DESCRIPTIONS

Subscale	Personal Growth Dimensions
1. Independence	The extent to which family members are assertive, are self-sufficient and make their own decisions
2. Achievement	The extent to which activities (such as school and work) are cast into an achievement oriented or competitive framework
3. Intellectual-Cultural	The degree of interest in political social, intellectual and cultural activities
4. Active-Recreational	The extent of participation in social and recreational activities
5. Moral-Religious	The degree of emphasis on ethical and religious issues and values

TABLE V

FES SYSTEM MAINTENANCE SUBSCALES DESCRIPTIONS

Subscale	System Maintenance Dimension
1. Organization	The degree of importance of clear organization and structure in planning family activities and responsibilities
2. Control	The extent to which set rules and procedures are used to run family life

The Family Environment Scale has been used in many different ways with a variety of populations. FES has been used in over 100 research projects with the abstracts of such projects cited in The Social Climate Scales: An Annotated Bibliography (Moos, Clayton, & Max, 1979). Research applications include exploration of the characteristics of different types of normal families -- e.g. one-parent families and multigenerational families. In addition, FES has been utilized by researchers exploring families in crisis or treatment type situations: families with a depressed member, alcoholic member, delinquent member; and families with a member in counseling or psychotherapy. Briefly, Family Environment Scale has been used in numerous ways with a variety of populations.

F-Copes Scale. The F-Copes Scale (McCubbin et al., 1982) was selected for use in this research because it was created to identify effective problem-solving approaches and behaviors used by families in response to family difficulties. Investigations have revealed that the family strategy of coping is not created in a single instant, but is progressively modified over time. Because the family is a system, coping behavior involves the management of various dimensions of family life simultaneously: 1) maintaining satisfactory internal conditions for communication and family organization, 2) promoting member independence and self-esteem, 3) maintenance of family bonds of coherence and unity, (maintenance and development of social supports in transactions with the community), and 4) maintenance of some efforts to control the impact of the stressor and the amount of change in the family unit. Coping then becomes a process of achieving a balance in the family system which facilitates organization and unity and promotes

individual growth and development (McCubbin, et al, 1982).

F-Copes is a 29-item instrument in which the respondents are instructed to answer each item on a Likert-type scale consisting of five alternatives: strongly disagree, moderately disagree, neither agree nor disagree, moderately agree, or strongly agree. F-Copes taps two dimensions of family interaction regarding adaptation to stress: internal family strategies and external family strategies. Internal strategies reflect the ways in which individual members deal with difficulties by using resources residing within the nuclear system: 1) Confidence in problem-solving (the family's appraisal of problems and their sense of mastery in dealing with unexpected events); 2) Reframing family problems (the family's orientation towards stressful experiences. In a broader perspective, this factor tries to tap how family views change -- positively, negatively or more neutrally); and 3) family passive appraisal (to balance the more active behaviors included in other factors, this scale deals more with "inactive" strategies a family might employ). The second dimension -- external family strategies -- concerns itself with what might be called the "active" behavior employed by the family in resorting to resources outside the "nuclear system:" 1) church and religious resources; 2) extended family members; 3) friends; 4) neighbors and 5) community resources.

Demographic Questions and Questions on Agoraphobia. In order to provide a socio-demographic profile of agoraphobics and non-agoraphobics, matters of age, education, family income, occupation, and family constellation were included on the instrument.

Questions dealing with the presence of agoraphobia and its manifestation were also included. To measure the intensity of the

illness, a form of Mark's Agoraphobia Scale was employed (Mathews et al., 1981). Duration of the illness was computed from a question asking the age at onset of the illness. The onset of the malady was defined by the date of the initial panic attack.

Survey Procedures and Statistical Analysis

Two copies of each questionnaire were enclosed in a single manilla envelope and given to the agoraphobic couples and the control couples. A cover letter accompanied the questionnaires requesting participation and suggesting that respondents complete the instrument separately. (See Appendix B and C for samples of the two letters.)

In conjunction with the substantively significant qualitative component, the quantitative data were subjected to empirical analysis. Given the descriptive nature of the project, the quantitative analysis was kept simple. Reported in Chapter V are frequency distributions for the major variables and Pearson Product Moment Correlation Coefficients. These coefficients shed light on the specific theoretical hypotheses developed in Chapter II. Following convention, the .05 alpha level was adopted as the decision rule for accepting or rejecting the null hypotheses.

Conclusions

This chapter has briefly outlined the qualitative and quantitative procedures utilized in this investigation. The specific chronology of the methodology (i.e., in-depth interviews providing the genesis for the questionnaire development) provided a sequential order and a thematic integration between the qualitative and quantitative dimensions of this

project.

The two levels of analysis will be reported in two subsequent chapters. Chapter IV provides a qualitative analysis abstracting and drawing conclusions from the four case studies (the complete verbatim interviews are included in Appendices F to I). Chapter V iterates the statistical findings drawn from the quantitative measures.

CHAPTER IV

QUALITATIVE RESULTS

> When a trout rising to a fly gets hooked on a line and finds himself unable to swim about freely, he begins with a fight which results in struggles and splashes and sometimes an escape. Often, of course, the situation is too tough for him.
>
> In the same way the human being struggles with his environment and with the hooks that catch him. Sometimes he masters his difficulties; sometimes they are too much for him. His struggles are all that the world sees and it naturally misunderstands them. It is hard for a free fish to understand what is happening to a hooked one.
>
> -- Karl A. Menninger

Family Descriptions

Four married couples, each with an agoraphobic member, agreed to participate in a single in-depth interviews with the researcher. All four of the agoraphobes participated in the interviews. Three of the four non-agoraphobic spouses were interviewed. One of the non-agoraphobic husbands made several appointments but did not keep any of them.

Within a conversational context the seven spouses were interviewed separately with each individual being asked open-ended questions regarding the agoraphobia and its influence upon self, marriage and the family. To capture the idiosyncratic nature of the malady within each of the four families, these summaries are liberally punctuated with direct quotations.

TABLE VI

DEMOGRAPHIC DATA OF THE FOUR FAMILIES PARTICIPATING IN THE IN-DEPTH INTERVIEWS -- THE IDENTIFIED PATIENT

Family	Family Member	Age at Onset	Age at Diagnosis	Age to Date	Education	Occupation
A	Wife	22	26	26	College 4 years	Housewife Self-employed
B	Wife	22	23	25	College 4 years	Housewife Self-employed
C	Husband	22	29	32	College 4 years	Commercial Artist
D	Wife	25	32	32	High-School	Physician's Recptionist

TABLE VII

DEMOGRAPHIC DATA OF THE FOUR FAMILIES PARTICIPATING IN THE IN-DEPTH INTERVIEWS -- SPOUSE

Family	Age of Spouse	Occupation of Spouse	Children	Years Married	Education of Spouse
A	27	Accountant	Son (2 yr.) Daughter (4 yr.)	6	College 4 years
B	33	Architect	None	2	College 5 years
C	33	Computer Analyst	Son (3)	11	Some College
D	41	Small Business	Son (8)	3	Some College

The ensuing portion of this chapter is devoted to abstracting the information presented by these agoraphobic families. The salient issues of these inquiries are the particular family configurations regarding onset of the agoraphobia, definition of the malady, effect of the illness on the family and coping strategies utilized by each of the family systems. This qualitative component served as an iteration of the idiosyncratic nature of the chronic illness, agoraphobia, within each of the family milieus.

Family A

At the time of interview, this couple been married for 8 years. They have a 2 year old son and a 4 year old daughter. Mrs. A is the identified patient and has been suffering from Agoraphobia for the past thirty-two months. Her husband is employed as an Accountant and she is works part-time teaching piano privately.

The traumatic onset of the panic attack was reflected in Mrs. A's crisp recollection of the event: "It was June 8, 1981. That date is very clear and even burned into my memory forever!"
Furthermore, she was careful to define the agoraphobia as the single most significant event in her life:

> Right now I would list the illness as the number one significant event of my life because of what it has done to me me and my ability to function. I can look back and list the birth of my children, and my marriage as some of my most significant times, but they haven't totally changed me.

Prior to the onset of agoraphobia, Mrs. A with an Bachelor's Degree in Music, was a pianist who was active in musical performances. Self-characterization was "a confident person able to handle any situation."

In similar fashion, her husband depicted her as "such a strong person." Subsequent behavior, however, finds her avoiding performance situations (e.g. piano recitals) for the most part and extremely uncomfortable in social settings. A case in point being:

> My family and the parents of my piano students have been after me for quite some time to do a piano recital but I'm not sure if I can do it. That's sad because I really want to, but I'm afraid.

The description of the mode of onset for Mrs. A began with the characteristic panic attack:

> All of a sudden it was as though I had a shot of Novocaine in my left arm. It wasn't even tingling . . . it seemed dead. Then the sensation began moving up into my shoulders and onto my face. Then it began moving down into my legs. Even my tongue . . . it got so thick I thought I was going to choke and suffocate.

The suddenness and intensity of the anxiety resulted in Mrs. A's insistence on being transported to the hospital's emergency room because "the chest pain convinced me I was having a heart attack." Mrs. A related this episode of acute anxiety to the context of childbirth:

> I had just given birth to my second child at the hospital's Alternate Birthing Center. Within thirty minutes of his birth I was out of bed, showered and into the next room receiving visitors. Twenty-four hours later, I was back home taking care of the new baby plus our 2 year old who was climbing over furniture and jumping off the table . . . doing all sorts of wild and crazy things because of the new baby.

In the Emergency Room and now convinced she was having a stroke, Mrs. A petitioned hospital personnel to re-admit her to the hospital. Subsequent examination and blood tests, resulted in an initial diagnosis of hyperventilation with "there's nothing wrong with you Ma'am."

Thereupon, she was sent home and with the prescription to breathe into a paper sack. Developing a near fetish-like attachment to this paper sack, Mrs. A related:

> I spent most of my time lying in bed with the paper sack. When the doorbell rang, that was it! I began gulping air and could not bring myself to go out to greet my visitors.

Initially, Mrs. A attempted to maintain minimal social and family functioning but finally gave up and went to live with her mother who lives approximately 50 miles away. "I had to go to my mother's house because I simply couldn't function. She took care of me for about a month. I tried to return to my own home once but ended up going back to Mother's."

Ensuing pharmacotherapy (anti-depressant and anti-anxiety agents) coupled with increased social withdrawal found Mrs. A relinquishing role responsibilities. Entire days at a time were spent sleeping. Consequently, at one particularly low period, she did not see the baby for weeks at a time and the infants care was assumed by family and friends. "I don't even remember the first ten months of my baby's life . . . . They are gone. I have no memory of him as a baby."

The element of doubt accompanying the agoraphobia is a predominant feature of this family system. Both members of this marital dyad articulated their commitment to the relationship and at the same time expressed elements of doubt about the future of the marriage. Also, Mrs. A wants to pursue a Master's Degree in Music but to do so would have to perform before a jury of the music faculty. The element of fear and doubt introduced by the agoraphobia precludes, at least for the present, graduate work in Music. In Mrs. A's words, "I don't know if I could

handle that (i.e., the music jury) . . . . I don't want to come apart at the seams again." This element of tenuousness appears pervasive.

The contours of Family A's interpretation of the malady seems to reflect an evolutionary process of three stages. First, there was Mrs. A's subjective interpretation of what was happening to her. Second, there were the labels attached by the medical community. Presently, in the the third stage, a family definition appears to be congealing around the agoraphobia's effect upon the family. These stages are discussed below in greater detail.

At the outset, the family's perspective of the illness was defined by somatic symptoms of chest pains, choking, dizziness, palpitations and a sense of unreality. These painful and frightening feelings were interpreted by the ill subject as indications of a brain tumor, heart attack, or stroke and ultimately death. Repeatedly, Mrs, A. felt she was going crazy.

From this irrational, emotional definition based on what Mrs. A felt was happening to her, the definition of the agoraphobia then became the prerogative of the medical community. Diagnoses vacillated among physiologic, biochemical, chiropractic and psychologic disorders and commenced with "simple hyperventilation stemming from exhaustion." The next diagnosis was from an obstetrician who dismissed her symptoms as, "You're just nervous." A constellation of diagnoses spanned the next twenty-four months: "the adrenal glands," "post-partum depression," "curvature of the spine," "diabetes" and finally "Mitral Valve Prolapse." These shifting interpretations of medical professionals served but to elevate the existing anxiety and confusion.

Currently, and within the third stage, the malady is being defined

more in terms of its effect upon the family system. Of primary significance is the family's translation of the agoraphobia in terms of futility. Though possessing the knowledge that she has agoraphobia, Mrs. A is no longer seeking the help of the medical community with her agoraphobia. Both spouses agree on the insensitivity of many physicians to the problem and consider them both cost-prohibitive and unproductive regarding agoraphobic diagnosis and management. This family feels the physicians have been rendered helpless by the agoraphobia and, furthermore, their own efforts towards remediation have proven ineffective.

Prior to the agoraphobia, Mrs. A described herself as competent and in control of her life and most situations. Subsequent to the first panic attack she became unsure of herself in social situation, avoids performing (piano recitals) and doubts her own worthwhileness. Her husband described her as a "before" and "after" person:

> Before the problem she was carefree, almost flitty; very sure of herself, feeling she could handle whatever came up . . . no problem! She was outgoing and enjoyed being around people. Now, she has become somewhat of a recluse; not nearly as outgoing or as outspoken; not sure she can handle situations and steers clear of certain situations . . . especially those situations where she must confront another person. For example, she will avoid confronting the parent of one of her piano students who simply is not paying their bill. She just will not call them and ask for the overdue payment.

These expressions of self-doubt are consistent with the subject's indications on the ten-item Self-Esteem Inventory. On five of the items, Mrs. A projected herself as not only a good person but a capable individual "able to do things as well as most other people." Though she thinks of herself as a person of worth, Mrs. A strongly agrees that she feels useless at times. While she does not view herself as a failure,

neither does she take a positive attitude towards herself. On the whole she is dissatisfied with herself and at times thinks of herself as "no good at all." Her husband, on his Self-Esteem inventory reflected similar attitudes of self-worth.

An obvious feature of the interviews with both spouses, was their high level commitment to maintain an intact family. Such pronounced commitment to marriage and the family, notwithstanding, the topic of divorce colored their interviews and Mr. A is beginning to question why he remains so committed to the marriage. The distance between this couple is reflected in the interview in that Mr. A feels the agoraphobia has invaded their personal relationship by putting distance between them -- "We are not as close." Mrs. A candidly admits that she does not need him as much as she did when they first married. This distance is perceived as the product of a seemingly constant state of misunderstanding regarding the illness and just how the non-agoraphobic spouse should respond.

The husband's estimate of the agoraphobia was succinctly expressed as: "one of the most crucial events of our marriage because it has changed our lives so and caused more friction between us than any single item."

Perhaps the most detrimental aspect of the illness to the marriage is Mrs. A's characterization of the agoraphobia as possessing a distracting, consuming quality which minimizes one's ability to relate and be involved with a spouse:

> When you are having a panic attack and your vision is distorted and your heart pounding, your entire thought processes are centered around the panic attack. It is not a matter of being selfish; when I am having a panic attack, all I can deal with is myself. I'm not trying to be selfish, but

> the panic attack is all-absorbing and I cannot give my attention to anything other than surviving I have told my husband, "Sometimes, it is all I can do to sit still and stay here. I'm just trying to keep my head above water and I can't deal with anybody else at this point."

Estimating the effect of the illness upon the marriage the husband responded:

> Only the death of a child could try a marriage more than agoraphobia. However, there is the promise of at least getting over the loss of the child. In this (agoraphobia) every day is a new day and you don't know when you return from the office what awaits you. The other day I found a note she had written about leaving me. She assured me she was just writing out her frustration. Still there is always that element of doubt that she will be there when I get home at the end of the day.

Thus, little if any communication between the spouses occurs about the agoraphobia. There seems to be a day-to-day quality about this family's life together: Concerned with her own survival, Mrs. A tries to make it through the day, and intent on the family's continuance, Mr. A tries to hold the family together for another day. The illness tends to circumscribe marital and family functioning.

Though working to maintain equilibrium in the marriage and family, Mr. A has significantly reduced his level of expectations from his wife and reconciled himself to receiving little of the caring and intimacy that characterized their marriage before the illness. To others married to agoraphobics, Mr. A advises:

> Not to expect to receive the warmth and care they were accustomed to receiving from their spouse. There will be no time for that. The time of their mate will be spent on self. Don't expect to get any pampering, care and very little sexual response.

To contend with the Agoraphobia, Family A initially employed

primarily two extra-familial resources -- medicine and religion. As has already been discussed, the family's immediate reaction to the anxiety attack was resorting to the medical community with an admission to an emergency room. In addition to what has already been written about this family's relationship with the medical community, several further observations might be made. Mrs. A requested the presence of her obstetrician. Complying with request, nursing personnel called the physician but he refused to see her and dismissed her symptoms as attributable to "just nervousness" and prescribed Valium. Three times Mrs. A requested this physician see her and three times he refused. Finally, she consulted her mother's physician who lived over 50 miles away.

In the quest for diagnosis of the malady the ensuing two years included medical consultations ranging from Family Practitioners, Obstetricians, Chiropracters, a Specialist in Diabetes. The search for medical assistance has been discontinued for purely economic reasons: "I have stopped trying to even find out what's wrong with me because we've just spent so much on this." Her husband, an Accountant, calculated:

> I have spent $3000 to $4000 in the last 24 months trying to get a diagnosis of what was going on. I'm very disgruntled (with the medical community). To a large extent, they seem to have been so apathetic about her problem and so caught up in their own specialty. We have been told, 'Don't worry. It will blow over.'

Frustration with medical professionals reached its zenith when a physician diagnosed Mrs. A as suffering from post-natal depression and prescribed anti-depressive, anti-anxiety agents with the statement that if the medication did not help he was going to admit her to the

psychiatric ward for observation. For fear of this hospitalization, Mrs. A has ceased seeking medical help and has been denying her illness to family and friends and defining it as "a heart murmur" and "I'm doing a lot better."

The second line of defense for this family, especially for Mr. A, in coping with the illness was Religion. Information resulting from the interviews of both spouses indicated their regular participation in organized religious activities and that church played a significant role in their family life. Mr. A served as an officer in his church and Mrs. A herself involved in directing certain church activities. Their friends were church acquaintances and Mrs. A indicated one of the initial environments she had difficulty navigating was that of the church sanctuary setting. This prevailing sense of religiosity was reflected by Mr. A as he identified hs faith in God as enabling him to survive his wife's illness. Christian love is a dominant tenet in his system of values. His wife does not love him in the romantic sense, yet he claims his love for her is not conditional upon her returning that love.

> I have come to depend more upon my religious faith to see me through. This has been a great strength to me. There have been times when I have not been able to cope with the situation so I have had to, in essence, turn it over to God.

In learning to cope with the malady, both husband and wife expressed their reframing of the illness. Mrs. A spoke of the positive results of the illness in terms of greater independence:

> In one respect, I am stronger and more independent because of it. All of my life . . . it was a standing joke -- point me in the right direction, so I could get there. I played the role of the scatterbrained type. When I went to college, I had to

> latch onto a man in a hurry so I could have someone to lean on. However, I am finding myself becoming more independent as a result of the illness. This may sound terrible, but when it (the agoraphobia) gets bad, my husband cannot help me, nobody can help me, and it's up to me to get through it.

In similar fashion, Mr. A reframed the malady in positive terms in that he felt it had served to not only heighten his awareness of the children, but increase his participation in child-rearing functions: "I think it (child care) should have been some of my responsibility all the way along, but I just wasn't shouldering it."

Whether from fear of stigmatization or embarrassment at having to explain to family and friends, the illness is either denied or the symptoms minimized. Now thirty-two months into the illness, Family A expresses extreme sensitivity to the agoraphobia. The interviews revealed that the illness is not openly discussed with friends and both Mr. and Mrs. A have been careful to identify the malady to their friends as somewhat benign. So much so, that their own family members (i.e. parents) aren't aware of the true nature of the illness. "They knew I had problems when the baby was born but have assumed I got better." Both spouses admit that their friends don't know about the agoraphobia. Extreme sensitivity to the illness has resulted in concealment from the subject's family and friends. With the exception of a very close couple, no one knows exactly what Mrs. A's problem is.

Within the interview, Mr.A felt a sense of solitude in trying to cope with his wife's illness. While she was focusing almost entirely on the agoraphobia and expending the majority of her efforts and energies just trying to cope with the problem itself, he was left to nurse both a sick wife and two small children. Mr. A reported his need for a significant other with whom to share some of his own confusion and

needs; someone to help him through it; an individual with whom he could talk and confide. One of the most difficult parts of his wife's illness, seems to be this absence of an intimate, supportive individual/s for the husband.

> I know I cannot know what my wife has gone through but neither can anyone else possible know what I've been through with this. The lack of sharing has been most difficult . . . no one to share with. You are wanting to talk with someone who knows something . . . someone who can sympathize and understand what I'm going through because they've been there -- a fellow sufferer. The mates of agoraphobics need to know someone else is facing the same thing."

In view of the effect the illness has had on the marriage and family, role expectations appear to have been synchronized around the agoraphobia's. Mrs. A, though not house-bound, feels strongly that she should maintain her former social and family responsibilities within the limitations of the Agoraphobia. However, when immobilized by the malady, she expressed the need for special understanding and not be expected to manage household affairs.

The husband seemed to indicate in the interview that he was willing to make concessions to her illness until he learned that it was "not something physiological." Implying that as long as agoraphobia is physiological in origin, he can excuse his wife's behavior and the family should adjust accordingly. However, since he feels this is evidently not so in his wife's case, it has become important for him to "keep things (the household routine) running. I could not stop and wait for her nor could I devote full-time attention to her problem. I always felt things have to go on as close to normal as possible if she is ever to work through the problem . . . ."

There seems to be a high degree of consensus as to what is expected

of each other. The ill subject is expected to continue with her household duties, social involvement, and child-care functions within, of course, the limits of the agoraphobia. The chronically disabling nature of the illness has resulted in compensatory involvement of the husband providing primary care of the children between 8 p.m. and 6 a.m. His activity in the home did not result from the expectations of Mrs. A but from his own dominant value of family responsibility. Both spouses identified Mr. A's change in parenting responsibility as perhaps the most significant role change precipitated by the agoraphobia. Mrs. A commented:

> The best thing he did was to take over the responsibility of getting up at night with the kids. Our two-year old does not sleep through the night. I don't mean he gets up once a night but two or three times every night. I could get up with him, but once I do I will not go back to sleep. My husband realized this and began getting up with the kids. It did not matter if he had only gotten a few hours of sleep, he was always the one to get up with the kids. I really appreciate this . . . considering he has to get up at six in the morning and I could sleep 'til ten if I chose to.

Within the interview, Mr. A reflected on his newly assumed roles and assessed his function as that of providing momentum by "keeping things running (in the family)" and also serving as ballast to provide stability to the family. He also feels responsible for protecting his ill spouse from negative emotional stimuli. Thus, he no longer shares their financial situation with her.

> Anything that looked like it might contain any friction or confrontation, I've handled. She has not known anything of our financial problems for the last two years. And going from doctor to doctor there have been numerous bills.

Mr. A's role of protector also extends to functioning as insulation

between his ill wife and in-laws who do not understand why their son caters so much to his wife. Unaware of the nature of her illness they feel their daughter-in-law has been negligent in her responsibilities and "not holding up her end of the family responsibility."

In summary, there appears to be consensus between this couple that Mrs. A is suffering from an illness called, "agoraphobia." Further, they define the malady as severely affecting their marital relationship and limiting their family's functioning. The agoraphobia has assumed a dominant, perhaps predominant role. Parental roles, spousal relationships and social mobility appear to be a function of the illness. The level of stress introduced by the agoraphobia appears to be manifesting itself in somewhat of a disintegrating form upon the marital unit.

Family B

This agoraphobic couple has been married for less than two years. He is a certified Architect, age 32, and she an interior designer, age 27. They have no children and their average family income is between $30,000-$40,00.

Mrs. B has been suffering from agoraphobia for the past 24 months. The context in which her agoraphobic symptoms began to emerge was during her last year at the university.

> October 1981 was the crash-in point when I cratered. I had just gotten engaged . . . . I had the trembles and was like a decrepit old woman . . . . I couldn't even pick up change (money) to buy a Coke because I was shaking so badly.

Accompanying the trembling was a feeling of tiredness and numbness in which she would experience the sensation of "rotation" -- a floating

sensation upon lying down and closing her eyes. The vertigo-like sensation was so powerful that she was afraid to close her eyes and relax lest she "float off into the air and never be heard from again."

The particular manifestation of Mrs. B's agoraphobia focuses on social setting. She has characteristically had difficulty with social functions. Although now Mrs. B is at least able to visit family during holidays and special functions. Still, she experiences heightened amounts of anticipatory anxiety.

> This was really quite frightening. I did not know what was happening to me and they could not help me understand. There was nothing to grasp or to explain it . . . . I didn't think I was going crazy until October of 1980. I couldn't figure out what was happening to me other than perhaps I was a weak person.

According to Mrs. B, agoraphobia with its debilitating nature "played havoc with my self-confidence. I still have difficulty thinking of myself as an interior designer worthy of $25 an hour. I feel rather fragile at times."

Low self-esteem did not always characterize Mrs. B. Prior to the agoraphobic onset, Mrs, B portrayed herself in terms of self-confidence. An outgoing personality, she was not only able to function in social contexts but was somewhat of an extrovert and actually sought out leadership roles.

> Previously, I was always busy. I was chairman of committees; a leader in school and participated in public speaking contests. In general I was outgoing and constantly on the go. I did enjoy (committee) meetings. I loved them. I even thrived on them. I was "little Miss Involved."

With the advent of the agoraphobia, radical changes occurred in

Mrs. B's level of social involvement. In conjunction with the socially debilitating aspect of the illness, this agoraphobic wife has internalized the malady to adversely affect not only her sense of self-worth but her over-all personality structure. These changes are perhaps best illustrated, and most obvious in the area of expressed anger:

> I get angrier now or I allow myself to get angry. Today I flipped a bird to a guy who nearly ran me off the road. Previously, I would just let it pile up inside me. But, for the first time, I can have a disagreement with someone and not feel badly about it.

Perhaps the most critical factor in the apparent stability of this marital system is the husband. His support is verbal in that he encourages his agoraphobic wife. His support is physical in that when his wife is feeling the results of agoraphobic symptoms or a tertiary manifestation of mild depression, he will sometimes physically embrace her and hold her for several hours. Reflecting on the nature of their relationship, Mrs. B related:

> Today at lunch, I was trying to think of any time when I have ever felt any impatience or exasperation from him to the point where I was sorry I had expressed any of my feelings towards him, and I couldn't think of any.
> I am learning to say, 'Hey, I'm really tense'. He is really affectionate and we are very huggable, snuggable. I need all that. The touching and hugging has pulled me through . . . there is a lot of touching, holding and talking.

Critical to this marital system's functioning, is what was expressed by the agoraphobic wife as as solid commitment on her husband's part to the marriage. She expressed feelings of confidence that "he wasn't going to walk out on me." This commitment seemed to foster a more honest exchange between this couple because of a secure,

trusting relationship. Within the individual interviews both Mr. and Mrs. B verbalized their love and commitment to each other. Echoing his wife's estimate of the secure relationship, the husband also expressed his commitment to do whatever was necessary to support and assist his wife with the illness:

> It doesn't cross my mind that I can back out and walk away. I don't think there has ever been a time when I thought 'This is too crazy for me, I'm going to leave'. Yes, I've been angry and impatient but I've made a vow that says whatever her problem is, I'm going to be right there. It is kind of irrelevant what her problem is . . . I'm in this relationship to stay.

Regardless of the verbalized mutual commitment, support, and over-all positive feelings expressed during their interviews, the demands agoraphobia makes on even a strong relationship became quite obvious. Mr. B portrayed the malady as possessing a unidirectional nature. Agoraphobia in a marital context seemed to create a one-way street kind of relationship, with the non-agoraphobic doing most of the giving. Mr. B related that even when his agoraphobic wife appears to be well, he was still careful to "tip-toe around for fear of upsetting the apple cart." It seems the focus of the marriage has been directed to the husband supporting and understanding his ill wife. Moreover, the husband felt his needs were second place to her agoraphobia. At that point, the non-agoraphobic Mr. B expressed what might be referred to as combined feelings of resentment and envy:

> I (sometimes) need somebody for a shoulder. Many times I've wondered, 'What about me? I've got problems, and feel like crying, too'. But I couldn't say that because we were focusing on her needs. Or when I come home upset, she was already crying.

Though admitting his wish for his wife's recovery, the non-agoraphobic husband still raises questions regarding the true strength of that relationship. Though expressing his wish for his wife's full recovery, he was candid in his admission that he has often wondered if he wanted her to get better. He feels good that she needs him and the possibility of remediation might remove the the need.

> I know this has to be back in the mind somewhere. If she gets rid of it (agoraphobia), will she still love me? I don't know, but I assume so. Will she still need me as much? Probably not.

In coping with the agoraphobia, secretiveness became a major issue. At the outset of the agoraphobia, Mrs. B felt she was transparent and that "people could see right through me to everything I was feeling." With the fear that her insecurity and agoraphobia were evident to every one because, "I just knew they would think less of me. Since I didn't feel very strong, I was afraid they would not thing of me as strong." Consequently, Mrs. B made an effort to conceal her fears and agoraphobic discomfort:

> I was a pro (at hiding the agoraphobia). All of us (agoraphobics) are pros at hiding it. I am not a nervous person. You will never see me fidgeting, biting my nails, wringing my hands or pacing the floor, (but on the inside) there is pure hell and havoc.

At the base of this secretiveness lay fear. Fear that "people might think we are weak and less that we should be." Though secretiveness characterized the first 12 months of Mrs. B's agoraphobia, she made the determination to tell everyone who attended her church the fact she had agoraphobia and suffered certain social limitations and asked their understanding. She felt this to be significant step towards

improvement in terms of her ability to cope both socially and individually.

> That was such a relief the Sunday I told the entire congregation I had a problem handling social situations. I felt freer to be open about it with them. My self-confidence really went up.

Besides the coping strategy of concealing the agoraphobia, Mrs. B has sought diagnosis and assistance from a variety of different professionals: physicians, neurosurgeons, chiropractors, and a psychiatric nurse. To help her cope, the physicians prescribed tranquilizers and anti-depressants. Over all, she was confused by their inability to help. Her husband expressed his feelings about the professional community's ability to cope with agoraphobia:

> I kinda feel down on doctors. I don't know just how many she went to but they each told her a different story about what was wrong with her. They didn't help.

Additional coping strategies for this particular couple has, from the beginning, involved the utilization of religious resources. Prior to agoraphobic onset, a rather active church life was important to Mrs. B. During the maelstrom of the initial agoraphobic symptoms, she turned to her faith for relief:

> I would turn to God and pray for strength and cry, 'I don't want to be like this'! I would hurt until I was exhausted. I had enough psychology courses in college to know I wasn't psychotic or schizophrenic. I knew I wasn't going crazy, yet I felt like it.

The turning point signaling remediation for Mrs. B was a seminar on agoraphobia conducted by a clinical psychologist specializing in agoraphobia. Consequently, she learned relaxation techniques and

reduced her prescribed medication consumption.

A significant reframing of the malady into productive terms emerged from the interview as helping to positively shape the remainder of Mrs. B's life:

> What has happened to me in the past two years will shape and determine how I live the rest of my life. When I was a little girl, my dreams and aspirations were college and marriage; that encompassed it. That's as far as I went in my thinking. I had never had any goals or any strong motivations. All that is different now. It is as though somebody threw cold water in my face and I have been reborn. Things are different now.

The duration of the agoraphobia in this case was relatively short -- only 24 months. Consequently, after individual and group therapy, ill subject, Mrs. B, feels she is recovering. Currently, she is not on any medication, nor has she taken any for the last 12 months. She is still driving an auto.

The non-agoraphobic husband in this case is unusually supportive of his agoraphobic spouse. At the time of their marriage, 24 months ago, he was cognizant of her illness. Though supportive of his ill spouse, Mr. B still verbalizes his thoughts which seemed to indicate that he has some question regarding the legitimacy of the illness:

> We all have crises and anxieties but most of us do not let it snowball like they (agoraphobics) do. I don't think a normal, strong, person would allow the agoraphobia to happen. I don't think I could ever let it happen to me because I'm not going to let that fear conquer; . . . Like alcoholics having a weakness they can't control . . . it is my feeling there is something weak in them and this is the reason they are like that.

Of all the four couples interviewed for this study, this family articulated the strongest expressive and cohesive elements in their marital relationship. The state of the relationship was usually

expressed in positive terms. Perhaps the most striking characteristic of Family B is the non-agoraphobic husband's support, verbal encouragement and physical expressiveness to his wife during agoraphobic symptomatology.

Family C

Mr. and Mrs. C live with their younger son (3 years old) in a suburban, Oklahoma area. Married for 11 years, both the spouses are employed. The agoraphobic member of this marriage, Mr. C, is a graphic designer and his wife is a computer systems analyst.

A linear perspective of this family's agoraphobia would commence with the anxiety attack in 1973. The ensuing seven years constituted an increase in the agoraphobic symptoms and a decrease in marital and life quality. A 1980 participation in the 15-week Agoraphobia Recovery Workshop signaled a crucial juncture in that the ill subject began managing the illness and devoting more time to his wife and family. At the time of this interview, Mr. C's agenda includes: 1) daily coping with the agoraphobia, 2) reconstruction of his marriage damaged by the malady and; 3) a secondary problem of the agoraphobia, severe depression.

Commencement of the agoraphobia for Mr. C occurred while he was driving on the Oklahoma-Missouri turnpike. Having just graduated from college and being newly employed in Oklahoma, Mr. C was commuting on week-ends back to Missouri where both parents and fiancee lived. In July of 1973, he was on route to Missouri via the turnpike and began experiencing feelings of entrapment. His initial reaction was to turn around and drive back to Oklahoma but with the Turnpike, as a limited

access highway, he was forced to continue driving to Missouri.

In his description of that first anxiety attack, Mr. C described the onset as shortness of breath and heart palpitations with extreme feelings of uneasiness. His interpretation of what was happening to him was that he felt as though he were trying to die "because it was such an incredible explosion of horrible feelings." Mr. C associated the anxiety attack with death because "all the alarms turning on inside me to call up all the reserves to keep me functioning, to keep me breathing, to fight the inevitable death."

Ostensibly, the magnitude of the anxiety described by Mr. C was incomparably violent and frightening. He iterated that physical pain was not alien to him because he had been in two automobile accidents and a motorcycle accident as well as having felt the emotional suffering from losing loved ones. He insisted that the agoraphobia was the most intense feeling he had ever felt in his life and never had he experienced any feeling in his body that frightened him or made him any more uncomfortable than those felt with the agoraphobia. Mr. C feels there is no comparable pain to that of agoraphobia.

> If I were sitting here with a little electrical plug attached to my finger and you told me that you were going to plug the other end of that plug into a socket and I would experience hell, I would say I have already been there and felt what hell is like. Hell is the most awful thing imaginable and to this point in my life I have not felt anything more hellish than I have felt in agoraphobia. On this side of death, there could not possible be a pain worse than the agoraphobia.

With the panic attack occuring in the context of travel, Mr. C's agoraphobia manifested itself in hypersensitivity to driving situations, especially those out of town on the highway. He became, in his own words, "city-bound." Whereas he could at least travel within the city

limits, driving on interstates and turnpikes was "a traumatic experience." Less traumatic, but difficult nonetheless, was driving within the city limits: "It puts quite a bit of pressure on you, but you can do it."

For fear of being disabled by another anxiety attack while driving, Mr. C would route courses. Before even getting into the automobile, he would plan a route to his destination that would take him by the closest hospital, fire station, medical clinic, or a place where he could get help if he needed it. For fear of another panic attack, this "routing" behavior persisted for 7 years. In addition to the difficulty with traveling, Mr. C also experiences problems with general mobility (e.g. attending movies, restaurants, parties, etc.).

Mr. and Mrs. C were engaged at the time of the first anxiety attack and were married a year and a half later. Mrs. C did not find out about the her husband's agoraphobia until after their marriage. Speaking without equivocation during the interview, Mrs. C was straightforward regarding her initially sympathetic and understanding response to her husband's plight. But after 18 months of contending with his agoraphobia, there was a significant change in her anger level towards her husband and her insensitivity to his problem. Having devoted a year and a half in both time and energy, she concluded it was up to him to resolve the problem and she had to get on with her life and that of their baby. When her husband enrolled in the Agoraphobia Recovery Seminar, Mrs. C elected not to attend the sessions with him even though spouse attendance was encouraged. Ostensibly, Mrs. C did not attend because of the infant son. She did, however, accompany him to the very last session.

The nadir of both the agoraphobia and the marital relationship was in 1979. This particular time was highlighted by an Mrs. C's absence from the home to attend a business conference in California. Her husband broke down, wept, and asked her to cancel the trip so he would not have to be alone. He took her to the airport the next morning, but only after he called his mother in Missouri and asked her to come and stay with him. Mrs. C's response to this was,

> This guy is a nut! Thirty years old and going to have mommy come down and stay with him. He's a basket case. I've got to get out of this mess.

At present, Mr. C still prefers his wife not leave town on business and she admits, "He is getting better about it. He is becoming more self-reliant, which he wasn't at all, and he is more confident."

Though Mr. C feels he is eighty-five percent recovered from the agoraphobia, he has developed secondary symptoms of serious depression. His goal in life is to get back to "even ground."

> Every agoraphobic I've ever talked with just wants to get back to "even ground." They hold out the hope they can recover the ground they've lost. That's what we are clawing for -- just to get back to where we were before. I would just like to get half the load off and get back to where everybody else in the world is . . . back to where I was in 1973.

To date, Mr. C considers the agoraphobia to be at least at a manageable level. His biggest concern, at present, is trying to manage secondary problems of depression where all he wants to do is sit quietly and stare at the floor. Coupled with the severe depression is the task of arresting the deterioration of the marital relationship. Mr. C has recently renewed his efforts towards the marriage and is investing more energy into the marriage than ever before. Both spouses addressed

themselves to the marital conflict resulting from the agoraphobia, yet both spoke positively of the marriage and their desire to work for a better relationship.

Over the last 13 years, Mr. C's agoraphobia has been defined in a multiplicity of ways. Similar to Family A, this couple's interpretation of the malady seems to be evolving. Both spouses agreed that one of the major problems they confronted was the inability to put a label on the agoraphobia.

> I went to doctor after doctor, and they told me nothing was wrong with me. After a period of time, through a process of elimination, I concluded I must be going crazy. They said there was nothing physically wrong with me. The best physicians in this city checked over every inch of my body and told me there was nothing wrong with me. I concluded something mentally was wrong with me. Being crazy was the only thing left. Then, when I really got confused, I went to psychiatrists and they told me there was nothing wrong with me. They tested me for symptoms of schizophrenia and mental disorders and again concluded there was nothing wrong with me. Then I was thoroughly, totally confused about what these feeling were.

While Mr. C was struggling with the agoraphobia and a correct definition for his problem, Mrs. C was superimposing over the illness a definition which included restriction. Mrs. C's image of the malady was that of its limiting nature: limiting her husband to Tulsa, limiting him to the confines of their house, and in particular, limiting him to the confines of the couch. One of her goals is for their family to be able to go to the park, go canoeing, and take vacations.

Mr. C described agoraphobia's effect on self-concept as a slow tearing own process. Prior to July, 1983, Mr. C described himself as,

> Proud. I was proud. Proud of my achievements in my high school and college career. I was happy with myself. I was looking forward to stepping out of the educational phase of my

> life and getting into the rest of my life with the beginning of a family, the beginning of a career. I was really looking forward to that. For 22 years, my life has been building up for the good. Then in 1973, it all began crumbling away. Where before I had feelings of high self-esteem and pride . . . they all crumbled and eroded away.

During this same period of time, Mr. C was having up to 20 panic attacks each day. The debilitating effects of both mentally and physically trying to handle the panic attacks was accompanied by a general sense of unfairness.

> Agoraphobics carry a double load and they go up the same hills everybody else does. I would just like to get half the load off and get back to where everybody else in the world is. I almost feel cursed. I still have to ask myself in prayer to God Himself, why I have this.

The problems became progressive. First there was the agoraphobia. Then, the agoraphobia developed secondary concerns included the possibility of Mr. C losing his job, losing his wife, losing his house, and even losing his life. He felt he was losing everything.

Irreconcilable barriers were erected between them. Now they don't talk about the agoraphobia. Mrs. C still feels that much of the agoraphobia symptomatology is incredible. At times, she questions the reality of the malady and wonders "just how much is dramatics and how much is real."

Accompanying sequelae include Mr. C's becoming introverted, scared, depressed, non-communicative, avoiding almost all social situations coupled with a prevailing sense that something was terribly wrong with him.

The effects of the agoraphobia are evident, not only upon the marital relationship, but upon Mr. C's self-esteem. Mrs. C is a very

strong personality who prides herself in "not taking anything from anybody." Perhaps the greatest deterioration in self-esteem resulted from his wife's anger.

> Agoraphobia has molded and shaped me into a person she doesn't like anymore. Many times she tells me, "I just don't like you anymore. I liked you when we got married but I don't like the person you are now." I feel that underneath all the hurt and pain there is still a Mr. C there -- there is still an ember there. But there is a lot of scar tissue. When your wife hits you with, "Why in hell did I marry a weakling like you!" Boy, that hurts. Sort of the icing on the cake.

Mrs. C related that, before the agoraphobia, he was a real, happy-go-lucky fellow. He made good grades in college and was self-reliant with a positive good self-esteem. She also related that he has no self-esteem and little self-reliance. "Just really pathetic. Totally dependent on input from other people. No confidence." In response to how her respect for her husband had been affected by the illness, she admitted that she had, on occasion, "thought he was a wimp." Conversely, Mrs. C said she knows full well he is "a normal guy" and "real smart."

A medley of coping strategems have been used by family C to cope with the agoraphobia. The ill subject related that he had been to numerous physicians and psychiatrists. Each performed a number of diagnostic test and each sent him away with, "There is nothing wrong with you." Mr. C feels confident he has spent $15,000 on diagnosis and treatment within the last 10 years. In 1983 alone, he spent $2000 treating a secondary symptom of agoraphobia -- depression.

> The majority of the doctors don't know what is going on with us and they contribute to the problem by telling us, "Well, I can't find anything wrong with you." You feel lousy and are told there is absolutely nothing wrong with you. And you

wonder, "If I'm so healthy why do I feel so bad!?"

Physicians prescribed a low dosage of Transene for the chest pain. Though Mr. C rarely takes this medication, he feels secure knowing its availability. He likened the secure feeling he got from the medication to the cartoon character in Charlie Brown (Linus) that drags his security blanket around wherever he goes.

Suicide also became a very real option to coping with the agoraphobia. At the nadir of the agoraphobia, he seriously considered taking his own life. Mr. C even had the whole thing planned out. At that point, however, he seemed to feel like he was getting better.

> The thing that really frightens me is that I've held up my shield and fought off the agoraphobic rocks thus far. But it gets so miserable on this side of the fence that death seems preferable. Finally, I got to where I was ready to risk seeing what it was like on the other side of the fence.

Fortunately, however,

> I was one of the fortunate ones who found out what was wrong. Finding out what it is, that it has a name, that there a lot of other people who are afflicted with it, talking with other agoraphobes, hearing them talk about the suffering they are enduring, understanding the physical changes in your body when a panic attack hits, all these things help you to get through it. All of a sudden there is a reason for what is going on. The agoraphobic is desperately seeking information he can lay his hands on to understand what has happened to him . . . . I knew I was sick but no one could tell me what was wrong.

Mr. C felt the constant need to talk and share his feelings and difficulties. He had allowed the agoraphobia to isolate him socially and has admittedly lost friends over the malady.

> For years, I did not talk to anyone. People looked at mean said I wasn't a very friendly person. After people ask you to lunch three or four times and you turn them down repeatedly,

> they conclude, why bother with him anymore. Or other couples invite my wife and I to the movie several times and after repeating, "My husband is not feeling well this evening . . . . My husband is not feeling well this evening . . . . My husband is not feeling well this evening. Finally, they just give up."

Mr. C is reluctant to open himself up to others and generate a supportive network. Historically, when he has opened himself to others and said, "I keep having these spells where I become anxious and cannot go to work" the reaction has been, "What do you mean you can't go to work? Grab a hold of yourself!" and other comments which have meant, "You are not grown up yet," "I thought you were an adult," "Accept some responsibility," "Be a man," "Stop crying in your beer," "Act like a man," and "You should've gone to the (military) service, that would've straightened you out."

Perpendicular to these predominantly non-supportive, non-understanding experiences, a singular bright spot in Mr. C's relationships existed in the person of his employer. At a time when it appeared Mr. C would have to fly to New York to represent his firm, the very thought of flying was so terrifying that he wrote out his resignation and walked into his employer's office to present his letter in person.

> I knew I would be terminated from the firm. But that day the agoraphobia was so bad that I had accepted the loss of everything. It would have been no different walking down the corridors to the gas chamber . . . it was the end of everything, the end of my joy. The end of my nice home. The end of my marriage. All was gone.

Rather than being terminated from the agency, Mr. C's employer said, "Close the door and tell me what your problem is and what I can do to help." Later, this same man paid over $700 to enable Mr. C to attend

the Agoraphobia Recovery Seminar.

For the first year and a half of the agoraphobia, Mrs. C was understanding of her husband's illness and was not only expressive in her sympathy and concern but seemed to make an exception for him because of the illness. He would come home at six O'Clock in the evening with his energy level "collapsed to nothing," go straight to bed without eating dinner, sleep to 10 P.M., eat, and then go back to bed. After the first eighteen months of this lethargic behavior, Mrs. C subsequently restructured her expectation level of her husband. She now feels he has had sufficient time to recover from the malady and should resume normal role functioning. Both spouses concur that Mrs. C makes no allowances for his agoraphobia. This last summer, Mrs. C bought airline tickets for both of them to the Bahamas for a vacation. Though cognizant of his fear of flying, she insisted that both of them were taking this vacation and he could not use his agoraphobia as an excuse not to go.

Mr. C is currently exerting efforts, heretofore nonexistent in their relationship, toward being aware of his wife's needs.

> I'm devoting time to my wife. I'm just talking about the conscious effort of listening to her and asking her what kind of day she has had and how she feels. I'm now asking her what she wants for Christmas. I'm taking our son to the playground. I am taking the time to do the things agoraphobia took from me.

Having remained somewhat at a denial level for a long time, there seemed to be an almost conspiratorial effort not to talk about the agoraphobia. Thus, few people knew about the illness. A couple of close friends know he tends to be nervous and has stomach problems. He did confide in a very close friend who is an medical doctor and told him

about the agoraphobia, but the doctor/friend did not know what he was talking about. Those who are aware, know only that he has a problem called, "agoraphobia" with little information beyond that as to limitations and implications. While his parents know he has agoraphobia, Mr. C freely admits he has "never really shared with them the day-in, day-out struggle." For the most part, agoraphobics hide what is going on inside them until,

> They finally get to the point where they are exhausted and don't care any longer. Something inside them says, "You've got to tell someone because you and your body can't go on any longer." You need help and to let it out. The time for hiding is over. You go to the hospital, the psychiatrist, do whatever is necessary. You've got to let it out because the pressure is too great inside. The breaking point has been reached. By the time the agoraphobic gets to this point, he is in real trouble . . . serious trouble.

During the interviews regarding the impact the malady has had upon both marriage and family, rather strong statements were made:

> It has almost destroyed it. My marriage right now is frayed. It is shot to pieces. In the beginning, my wife was sympathetic to my problem. But after a year and a half, those feelings of sympathy turned to other feelings of, "I don't understand what is wrong with you, <u>you</u> don't know what is wrong with you, and I'm tired of seeing you lie around here. You won't take me out to a movie, you won't let friends come over, you won't take me out to eat, you won't talk to people, you don't talk to me like you used to, and our life together, our love life, is diminished.

As a result, the problems became cumulative. Mr. C is left with not only battling the agoraphobia but fighting to keep his marriage together. One of the most significant obstacles is his wife's anger. Where there were once expressions of tenderness and sympathy, anger is resident.

> For me they have been physical. She has hit me because she was so angry. She has called me everything under the sun -- painful, scarring phrases. You have to understand, in my former self I am a luxury liner and all of a sudden I am a sinking ship. I don't know how to stop the leaks. Suddenly I'm getting more holes punched in me by my wife . . . . I don't know whether or not we will ever recover from this or not . . . I just don't know. My wife really got hammered. I didn't hammer her but it was (my) limp body on the couch for months at a time that got her. The unresponsive, exhausted Mr. C got her. And to a young woman, normal in every way that is progressing in every way, her work, her career . . . she is wanting to get on with life: "Let's be saving for a home," "Let's be planning for the future," and I couldn't even plan for the next day . . . . We have a beautiful three and a half year old son that is really the glue that keeps us together right now. I don't think if he wasn't there, we would be together now. It isn't because I don't want her, it is because when she looks at me she sees the agoraphobic Mr. C. She can't forget. It has been that much pain to her.

Unfortunately, spouses take the agoraphobia personally, and it gets into a personal hurt situation.

> Just how much can you ask a person to endure? It's a terribly hard thing to ask your wife to endure something like this. You've got to realize that the person they married is not there anymore. He or she still looks the same but they've changed. They are crumbling before your very eyes. They are fighting . . . fighting for their very survival. Everything has changed. All the rules they were playing by have all of a sudden gotten mixed up . . . . Understand that it is difficult for me to be a romantic, loving caring husband. Quite honestly, I haven't had a lot of experience with those kind of feelings since we've been married for ten years and fighting agoraphobia ever since we've been married. There hasn't been a lot of time for the role of looking out for my wife. These are hard things for me to say, but they are absolutely true. Over the past couple of years, I've devoted more time to my son and my wife than I have in all the previous years. But it might be too late . . . just might be too late for us. Again, I don't know. If the marriage does fail, I'm not looking for a scapegoat, but I can honestly look to the agoraphobia and what it did to me, and ultimately, to my family.

Mr. C is quite clear about what agoraphobics want to hear from their spouses.

> "You and I are going to team up together and get through it together. You are going to have a partner all the time for as long as you want me. I am going to help you through this. I love you and I am going to help you get through this problem." These are the words I would like to have heard . . . without a doubt. This would mean a lot.

The agoraphobia served to interfere with their intimate relationships. The non-agoraphobic Mrs. C would like a closer relationship than they presently have.

> I am playful. We can't do that. I want some hugs and contact other than just in bed. He's not that way. He is not playful before or he's not playful anytime. He doesn't hug the baby and wrestle around or rough him up like dads do. I stop and tell him, "You need to hug the baby . . . hug him up and tell him you love him." And he will do it. He's getting better about it, but is just not real forward with it at all . . . . I think we both realize we are going to stick together. Although, he is not real demonstrative.

Summarily, this is a family of antithetical individuals. The non-agoraphobic Mrs. C presents herself as a strong-willed, verbal, confrontive, and assertive personality, prone to expressions of anger and impatience, especially with her husband's agoraphobia.

The effects of the malady upon both members, but especially the identified patient seems pronounced. At one point he had his suicide planned out. However, as a result of both group and individual therapy, he feels he is no longer at that extreme point of sadness. Though no longer dominated by the illness, he has developed secondary symptoms of severe depression.

As Mr. C was "fighting for personal survival" his marriage stood "second in line." Therefore, while Mr. C was "building up a shield to fight off the agoraphobia," his wife was "building up a shield of her own against him." A wall of anger and frustration has been erected

between them. Mrs. C defined herself as being "real short fused." Her initial reaction was that her husband just needed to "snap out of it . . . . I knew he was a real normal guy but he was too messed up to do anything." She is still suspicious about all this because she cannot relate to someone who, for example, cannot go up an elevator. "I thought this is just a bunch of nonsense."

While this marriage is intact, the marital bond remains disjunctured and somewhat tenuous. The husband identifies his emerging participation in the family as consolidating the marriage and preventing further relaxation of the marital relationship. His efforts include giving time and attention to his wife and child, making his bed in the morning, cleaning up dishes at night, and in general, helping around the house.

For the last 11 years Mr. C has struggled with the agoraphobia. While the agoraphobia is now felt to be at least manageable, Mr. C, he is now confronted with picking up the pieces of a deteriorating marriage. The agoraphobia symptoms are better, "but the scars remain."

Family D

Mr. and Mrs. D have been married for two years. This is a remarriage for both of them with each retaining custody of children from the previous marriage. Mrs. D is 32 years of age and is the one suffering from agoraphobia. She is employed full-time as a receptionist for a Pediatric Opthomologist. At 41 years of age, Mr. D is a retired fireman and the owner of a small business.

The onset of the agoraphobia for Mrs. D occurred in December, 1976 during divorce proceedings from her first husband. The initial anxiety

attack occurred in the context of alcohol and marijuana.

> I'm not a drinker or anything like that, but I was upset over the separation and some other problems so my friends handed me a drink and a joint of marijuana and told me to loosen up. This was the first time with marijuana. I soon began to feel lightheaded and then felt like I was going to die. I was screaming bloody murder, "Take me to the hospital!"

Prior to agoraphobic onset, Mrs. D defined herself as uninhibited and a social being.

> I was gone every week-end doing something. I drove places by myself. I was invited everywhere. I liked myself and other people like me, too.

Subsequent to the agoraphobia, however, Mrs. D related that she did not like herself. She thought she was a good person with good ideas but did not like herself. The overwhelming nature of the anxiety attacks sufficiently impacted Mrs. D's perception of herself as capable and able to care for herself. Repeated panic attacks resulted in selling her house and moving in with her mother. She remained there for over two years. For the most part housebound, Mrs. D would occasionally leave the house with her mother to eat out.

The immobilizing effects of the malady were such that Mrs. D couldn't keep a job. She would get scared and leave the desk in a panic.

> I work for a doctor on the tenth floor. When I would would have to go down, say to the third floor, I would have to call my father who lives 20 miles away and have him to come and meet me there because I was afraid to go down by myself.

For fear the agoraphobia will incapacitate her and she will die, the presence of others has become paramount.

> I don't know what the difference is, but if you went to the park with me and my son, I would feel real secure because you are there in case something happens to me. Yet I know that if something was going to happen to me you couldn't stop it. Nobody could. But I can't get this out of my mind.

Not only does Mrs. D lack respect for herself, but her family does not respect her. Her mother or brother will often plan Mrs. D's day off without even asking her. Rather than confront them with their presumptuous intrusion into her life she elects to just put up with it.

> I just cuss and mumble under my breath and nobody knows. I'm just like Rodney Dangerfield: I don't get no respect.

At the outset, Mrs. D attached a medical definition to the malady and sought relief from the medical community and more especially the hospital emergency room. Mrs. D related that she frequented the emergency room of one particular hospital with such regularity that she and the hospital personnel knew each other on a first-name basis. At this point she was going to the hospital every other night.

> From 1977 until now, I've spent over $20,000 on psychiatrist, doctors, emergency rooms, and prescriptions. Twenty thousand easy. I have spent entire weeks in the hospital with this (agoraphobia).

During that time, she became addicted to the prescribed medication (Valium). Since then, however, she has become very conscious of her health and takes only Transene.

After losing faith in the medical model, Mrs. D. moved to a psychological definition. This agoraphobic female now defines the malady in intractable terms. She compares it to alcoholism in that she will have it for the rest of her life.

Secretiveness is a significant part of Mrs. D's response to the

agoraphobia: "I would rather die before I would tell somebody I was having a panic attack." Her employer, a physician, does not know. Her mother does not know.

> My mom knows I have problems but not that I have agoraphobia. I'm too afraid to let her know that I'm seeing a psychologist who specializes in agoraphobia because she would criticize it so much and I would feel guilty and quit. I usually do what she says.

Special affinity exists between Mrs. D and her 8 year old son as he appears to be the sole focus of her attention. Though overtly attempting to avoid letting her agoraphobia affect her son, she describes him as "a little agoraphobic . . . too cautious, afraid he will hurt himself." Repeatedly, Mrs. D expressed her regret that she feels she is cheating her son.

> I envy other women . . . women sitting at McDonald's with their kids and I envy them. I have yet to take my little boy to a part or a movie by ourselves. I don't like that.

According to Mrs. D., her husband, age 35, did not discover she had agoraphobia until after they were married. Although he agreed to participate in this interview, he did not show. Therefore, the information regarding this relationship is drawn from Mrs. D's interview only, and presents an incomplete portrait of this family system. However, several points are significant.

Because of the agoraphobia, Mr. D expresses his anger and frustration. He and his wife do not go out to eat. They do not go out to movies not do they have a social life. They have been married two years and have been out together perhaps twice.

> A couple of times we've tried to go out to eat and then to a movie. During the meal I get the attack and I'm too scared to

> go to the movie. He gets mad because he does not get to go out and I feel like, what's the use. I'm at the point where I don't care.

Negativism appears to play a rather large role in this marriage. Consequently, Mrs. D, rather than talk openly and freely about her problems, has become non-communicative with her husband.

> There are days when I am scared all day long . . . like a rabbit. And when I come home I don't need all that (negative comments). He thinks he is a very understanding person but he isn't. Last night we went out to eat, and in the middle of the meal my knees began shaking. I leaned over and told him I was having trouble breathing. He said, "Christ! You are so stupid!" Then the anger starts and I want to take my sandwich and rub it in his face. Makes me real mad. Then I resent him and don't talk to him . . . my way of punishing him.

Mrs. D admits being married to an agoraphobic spouse is difficult and, admittedly, a one-sided affair since the non-agoraphobic has to give more and receive less in return.

There appear to be significant amounts of interpersonal conflict between the spouses in this relationship. So much so, that Mrs. D admits she would divorce him now if she were not so scared. The agoraphobia keeps her in it.

Though initially excited about his wife's recovery from the agoraphobia, Mr. D, according to Mrs. D, feels uncomfortable with the progress his wife is making towards independence. "He ridicules me and says nasty things like 'you can't even go to the store by yourself' or 'if you left me, you couldn't even take care of your son'."

Mr. D's initial willingness to participate in this research project followed by his non-compliance appears to reflect Mrs. D's estimate of her husband. Though he seemed initially excited and supportive regarding her recovery, he may would later appear to sabotage the

therapy.

> He went with me at first and was real excited but the more independent I got, he ridiculed me, calling me a "psychiatrist's dream." He stopped going with me and quit giving me money to pay the psychologist. Now, I'm doing it by myself.

Mrs. D. separated from her in 1983 and during the separation seemed to manifest more control over her life. At the time of the interview, Mrs. D was expending her energy towards independence from both her mother and her husband.

Part of Mrs. D's coping with the agoraphobia has involved a reframing of the problem to include the positive aspects. Since the agoraphobia, she feels she has become more sensitive to people with needs . . . "handicapped people, people shut off from the world, people other people don't care about or notice."

When queried about the needs agoraphobics have, Mrs. D responded that she needed to hear that she was doing good. Even if all she had done was to stay home and clean up the house, she needed positive rather than negative.

> People married to agoraphobics should say, "If you would like, we could go out to eat." Don't say, "When are we ever going to go out to eat!?" Say, "If you would like, we'll go to the restaurant of your choice." Let the agoraphobic choose where they want to go because they know where they are comfortable. And when you do go out to eat with an agoraphobic and they say, "Could we leave now" or "could we go outside and then come back in," don't throw a fit. Say, "you're doing good" even if you don't mean it.

Summary

The interviews of these seven subjects consisted of three agoraphobic females and one agoraphobic male. With but one exception,

the non-agoraphobic spouses participated in the interview process.

There is a uniqueness about the composition of these agoraphobic families -- each portrays the idiosyncratic nature, not only of the malady itself, but of each family's particular response to the illness vis-a-vis coping mechanisms. Family A reflects the role that a strong religious faith can play in providing cohesion in the face of chronic illness. Family B is a succinct statement about the significant role that the healthy spouse plays towards both the remediation of the illness and the maintenance of the couple relationship. The non-agoraphobic husband in family B illustrates the significance of understanding and supportiveness in coping with a chronically ill spouse. Apparent in family C, are implications of long-term agoraphobia. This particular family has been under the stress of the agoraphobic malady for over a decade. Perhaps the most salient feature emerging from the interview of this family, is the avowed desire to continue the marriage and family and yet the obvious tenuousness of the relationship. Anger is more pronounced in this family than in all the others. The relationship in family D provides a marked contrast to that of family B, illustrating "sabotage" of the efforts of the ill member to return to health. Family D also highlights the transmission of an anxiety syndrome from the parental system to the agoraphobic child as well as the maintenance of the disability.

Several threads appeared to run through the skein of these agoraphobic families: a) the presence of felt or expressed anger, aggression and conflict among family members, b) deteriorating self-esteem within agoraphobic personalities, c) a diminishing level of commitment and support that non-agoraphobic spouses are providing their

ill spouses, d) a reluctance to be vulnerable and act openly and express feelings freely, and e) a reduced amount of participation in social and recreational activities.

True to the literature regarding chronic illness in the family, and as postulated at the outset of this investigation, the family is an integral factor in agoraphobia. Perhaps, agoraphobia should not be the sole prerogative of the psychological perspective but would benefit from an holistic perspective which incorporates all members of the ill subject's family system.

CHAPTER V

QUANTITATIVE RESULTS

The research study was designed to consider the recovering agoraphobic and the concomitant family system surrounding the malady. This chapter presents the results of that investigation into the family environments of the 35 participating female agoraphobics and the control group. Demographic profiles and other criterion data are presented to characterize the respondents for both sample and control populations. Beyond descriptive purposes, demographic variables are correlated with other items within the data collection instrument to serve as measures of the hypotheses.

Description of the Respondents

Table VIII presents the demographic characteristics of both control and agoraphobic families by age, average family income, and age of the children. Most apparent is the disparity between the two samples. The mean age of the husbands of agoraphobic females (43.6 years) stands in contrast to the control male's mean age of 33.2 years.

The two samples also vary in range and age distribution. Wives in both groups reflect similar differences in age, range, and distribution. Agoraphobic females ranged in age from 20 to 80 years with roughly equal distributions below age 40 (48.9%) and above age 40 (51.1%). All of the control females fell within the 20-40 year range with a preponderance

TABLE VIII

DEMOGRAPHIC CHARACTERISTICS BY AGE, AVERAGE FAMILY INCOME, AND AGE OF CHILDREN

	Control Families 1		Agoraphobic Families 2	
	Frequency	Percent	Frequency	Percent
Age				
Husband				
20-30	16	33.3	6	17.2
31-40	28	56.2	6	17.2
41-50	4	10.4	8	23.2
51-60	0	0.0	3	8.6
61-70	0	0.0	4	11.5
71-80	0	0.0	1	2.9
Wife				
20-30	19	39.5	9	25.8
31-40	29	60.5	8	23.1
41-50	0	0.0	11	31.7
51-60	0	0.0	5	14.4
61-70	0	0.0	2	5.8
71-80	0	0.0	0	0.0
Family Income				
Less than $10,000	3	6.3	3	8.6
$10,000-$20,000	2	4.2	6	17.1
$20,000-$30,000	8	16.7	2	5.7
$30,000-$40,000	10	20.8	10	28.6
$40,000-$50,000	6	12.5	4	11.4
$50,000 and over	19	39.3	10	28.6
Children				
No Children	0	0.0	6	17.1
Preschool Age	48	100.0	12	34.3
Junior-high Age	5	10.4	6	17.1
Attending College	0	0.0	8	2.9
None Left at Home	0	0.0	8	22.9

1. $\underline{n}$ of control families = 48
2. $\underline{n}$ of agoraphobic families = 35

(60.5%) contained in the 31-40 age bracket.

Agoraphobic families indicated a median family income between $30,000 to $40,000 while control families measured the average annual family income between $40,000 to $50,000. While virtually all the control families contained preschool through grade school children, only 12 of the agoraphobic families (34.3%) fell within this category. Roughly half of the agoraphobic families indicated "no children" (17.1%); "no children at home" (22.9%) or "children attending college" (22.9%). All the control group families had children and they were indicated as either "preschool-grade school" (100%) or "junior-high school" (10.4%).

Control families measured a higher level of formal education than the sample families with 54.2% of the husbands and 35.4% of the wives indicating postgraduate work. (See Table IX). The marked difference between the agoraphobic and non-agoraphobic families may be an artifact of the research procedure which utilized the Oklahoma State University Pre-school Lab and a Tulsa pre-school as sampling frames. With the average age of agoraphobic onset at 28 years, younger families were targeted in the control sample as approximating the age and family context in which the agoraphobic malady is likely to occur. Table X reflects a disproportionate number of non-agoraphobic controls with professional occupations (males = 75%; females = 29.2%) represented younger families with more education and larger income than the agoraphobic families.

Aside from the general descriptions iterated above, Table X also indicates 28.6% of the agoraphobic subjects were employed full-time, 25.7%, part-time, and 45% not at all. Roughly 50% of both agoraphobic

TABLE IX

DEMOGRAPHIC PROFILE FOR MARITAL STATUS AND EDUCATION

	Control Families 1.		Agoraphobic Families 2.	
	Frequency	Percent	Frequency	Percent
Education				
Husband				
Grade School	0	0.0	1	2.0
Some High School	0	0.0	0	0.0
Graduated H. S.	1	2.1	3	8.6
Some College	9	18.8	10	28.6
Graduated College	12	25.0	7	20.0
Postgraduate Work	26	54.2	8	20.0
Wife				
Grade School	0	0.0	0	0.0
Some High School	0	0.0	3	8.6
Graduated H. S.	3	8.3	11	31.4
Some College	13	27.1	10	28.6
Graduated College	15	31.3	7	20.0
Postgraduate work	17	35.4	4	11.4
Marital Status				
Husband				
Married	44	91.7	23	65.7
Remarried	4	8.3	5	14.3
Widowed	0	0.0	0	0.0
Wife				
Married	43	89.6	28	80.0
Remarried	5	10.5	6	17.1
Widowed	0	00.0	1	2.9

1. n of control families = 48
2. n of agoraphobic families = 35

TABLE X

DEMOGRAPHIC PROFILE BY OCCUPATION AND WIFE'S EMPLOYMENT

	Control Families 1.		Agoraphobic Families 2.	
	Frequency	Percent	Frequency	Percent
Occupation				
Husband				
Professional	36	75.0	14	40.0
Farm Managers	0	0.0	0	0.0
Managers	4	8.3	1	2.9
Clerical	0	0.0	1	2.9
Sales	4	8.3	8	22.9
Craftsmen	1	2.1	3	2.1
Operatives	0	0.0	1	2.9
Private Household	0	0.0	0	0.0
Service Workers	2	4.2	0	0.0
Laborers	0	0.0	0	0.0
Wife				
Professional	14	29.2	7	20.0
Farm Managers	0	0.0	0	0.0
Managers	3	6.3	0	0.0
Clerical	4	8.3	7	20.0
Sales	2	4.2	1	2.8
Craftsmen	0	0.0	0	0.0
Operatives	0	0.0	1	2.9
Private Household	25	52.1	19	54.0
Service Workers	0	0.0	0	0.0
Laborers	0	0.0	0	0.0
Wife's Employment				
Not at all	23	47.9	16	45.7
Part-time	9	18.8	9	25.7
Full-time	16	33.3	10	28.6

1. $\underline{n}$ of control families = 48
2. $\underline{n}$ of agoraphobic families = 35

and non-agoraphobic females characterized their employment as "private household" or "housewife."

Profile of Agoraphobic Subjects

In addition to the above comparisons between control and sample populations, the agoraphobic females indicated an average age of onset at 27.9 years. (See Table XI.) This value parallels Mark and Herst's (1970) estimate of a mean age of 28 and presents a reasonable agreement with different reported series: 24 years (Marks & Gelder, 1966), 28 years (Burns & Thorpe, 1977), 29 years (Marks & Herst, 1970), and 31 years (Buglass et al., 1977). Furthermore, the study reported that nearly 10% of the agoraphobia started after age 40 and 20% at age 20 or before. The distribution of the age of onset for this particular sample peaked between 21-30 years (51.6%).

Table XI indicates that, although the range of duration was from 1 to 37 years, roughly 40% of the agoraphobic females have been suffering from the illness from one to eight years. Only two of the subjects (5.8%) reported the presence of the agoraphobia for more than 24 years. Another 40% fell into the category of 9 to 16 years.

The intractable nature of the agoraphobic malady was reflected in the 11.7 year average length of the illness. Though having attempted remediation through several months of an agoraphobia recovery workshop involving both individual and group therapy, the respondents still indicated the illness to be "definitely disturbing and disabling." (See Table XII.) With the agoraphobic females indicating 40.5 years as a mean age and 11.7 year duration of the illness, the malaise had been a presence in the respondents' lives for almost a third of their lives

TABLE XI

DISTRIBUTION OF THE AGORAPHOBIA WITHIN THE SAMPLE POPULATION BY DURATION AND AGE OF ONSET

	Years	Frequency (n =35)	Percent
Duration			
	0- 4	7	20.0
	5- 8	8	22.9
	9-12	6	17.3
	13-16	8	22.9
	17-20	1	2.9
	21-24	3	8.6
	25-28	0	0.0
	29-32	0	0.0
	33-36	1	2.9
	37-40	1	2.9
Onset			
	1-10	1	2.9
	11-20	6	17.3
	21-30	18	51.6
	31-40	7	20.1
	41-50	1	2.9
	51-60	1	2.9
	61-70	1	2.9

TABLE XII

THE INTENSITY OF THE PRESENT STATE OF AGORAPHOBIC SYMPTOMS AS RATED BY THE AGORAPHOBIC SUBJECTS

Intensity	Frequency (n =35)	Percent
Slightly disturbing/ but not really disabling	12	34.3
Definitely disturbing/ and disabling	16	45.7
Markedly disturbing/ and disabling	6	17.2
Severely disturbing/ and disabling	1	2.9

Examination of the Hypotheses

The purpose of this investigation was to take a step toward describing the family environment surrounding agoraphobia. Since the emphasis was on description rather than hypothesis-testing per se, the many specific research questions were collapsed into related groups of hypotheses to facilitate discussion.

In view of the goal of examining not only the agoraphobic member but her non-agoraphobic spouse, no compelling reason seemed indicated to predict direction in the formulation of the hypotheses. Therefore, they are stated in the null form.

> Hypothesis 1: There are no statistically significant relationships between the incidence, duration, severity, and age at onset of agoraphobia in the wife and her self-esteem.

Pearson correlations were calculated between the items contained in the Rosenberg Scale and the Osgood Scale, and the presence of agoraphobia -- its duration, severity, and age of onset. (See Table XIII.) The first two associations are between the presence of agoraphobia and: 1) self-esteem as measured by the Rosenberg scale, and 2) self-esteem as measured by the Osgood scale ($n = 83$).

The majority of the agoraphobes indicated they possessed a number of good qualities. Still, 75% indicated either agreement or strong agreement with the item "I certainly feel useless at times." This marked self-doubt, coupled with general feelings of pessimism and lack of confidence, emerged in strong associations between the agoraphobic illness and the Rosenberg ($r = -.63$) and Osgood ($r = -.50$) measures. While not implying causality, these negative correlations supported the

TABLE XIII

CORRELATIONS BETWEEN AGORAPHOBIC CHARACTERISTICS AND SELF-ESTEEM

	Self-Esteem	
	Rosenberg Scale	Osgood Scale
Females		
Presence of agoraphobia	-.63***	-.50***
Duration of agoraphobia	-.31*	-.19
Intensity of agoraphobia	-.33*	-.42**
Age at onset	.32*	.32*
Males		
Presence of agoraphobia	-.09	-.13
Duration of agoraphobia	-.21	-.01
Intensity of agoraphobia	-.15	-.17
Age at onset	.29	.28

*$p \leq .05$
**$p \leq .01$
***$p \leq .001$

Note: n for correlations with presence of agoraphobia = 83 (agoraphobic and non-agoraphobic S's); n for correlations with duration, intensity, and age at onset = 35 (agoraphobic S's only).

negative association of this particular malady with self-image.

The next three pairs of associations related only to those wives suffering from agoraphobia (n = 35). These associations were between related aspects of agoraphobia (duration, intensity, and age at onset) and the Rosenberg and Osgood measures.

As can be seen, there was a significant relationship between the length of the affliction (duration) and self-esteem as measured by the Rosenberg Scale (r = -.31). The presence of the illness over time appeared to exacerbate feelings of worthlessness and low self-esteem. However, this association was not borne out with the Osgood Scale which failed to achieve significance (r = -.19).

Table XIII also indicates that the more pronounced the malaise was perceived to be and the more disabling in nature (intensity), the lower the feelings of self-worth (Rosenberg: r = -.33; Osgood: r = -.42). Finally, the findings reflected a positive correlation between the age of agoraphobic onset and self-esteem. Both the Rosenberg and Osgood scales resulted in values significant beyond the .05 level. The age at which the subjects experienced their first panic attack, signalling the onset of agoraphobia, seemed related to their ability to maintain feelings of self-worth (r = .32). The implication being that older age of onset is related positively to maintaining feelings of self-worth.

The findings, therefore, appear to provide grounds for rejecting the null hypothesis. Low self esteem appeared to be significantly associated with the presence of agoraphobia.

> Hypothesis 2: There are no statistically significant relationships between the incidence, duration, severity, and age at onset of agoraphobia in the wife and the husband's self-esteem.

Table XIII also reports correlations between the agoraphobic environment of the husband (whether he lives with an agoraphobic wife (i.e., husband is a "spouse") or a non-agoraphobic wife (i.e., husband is a "control"); n = 83) and the husband's self-esteem. Whereas the presence (or absence) of agoraphobia in the wife was clearly related to the wives' self-esteem, there was apparently no corresponding phenomenon among the husbands ("spouses" and "controls"). The relationship between presence of agoraphobia in the home and husband's self-esteem was non-significant (Rosenberg: r = -.09; Osgood: r = -.13).

The related measures of agoraphobia (duration, intensity, and age at onset) apply only to husbands whose wife suffer from agoraphobia ("spouses;" n = 35). As can be seen in Table XIII, the strongest relationship existed between the wife's age of onset and spouse self-esteem on both Rosenberg and Osgood (r = .29 and r = .28 respectively), but both correlations failed to achieve the .05 level of significance. Thus, the null hypothesis stated in Hypothesis 2 is not rejected: there is no statistical relationship between living with an agoraphobic and the severity of her illness and the husband's self-esteem.

> Hypothesis 3: There are no statistically significant relationships between the incidence, duration, severity, and age at onset of agoraphobia in the wife and her perceived level of individual tension.

The results of the correlation between the agoraphobia items and the level of tension are presented in Table XIV. When the data are examined, the strongest relationship with tension came from presence of agoraphobia (r = .37; n = 83) and age at onset (r = -.33; n = 35). The manifestation of agoraphobia was accompanied by increased amounts of

TABLE XIV

CORRELATIONS BETWEEN AGORAPHOBIC CHARACTERISTICS AND OTHER CRITERION VARIABLES

	Tension Level	Education	Wife Employment
Females			
Presence of agoraphobia	.37***	-.44***	-.01
Duration of agoraphobia	-.01	-.01	.03
Intensity of agoraphobia	.26	-.05	-.02
Age at onset	-.33*	.06	-.10
Males			
Presence of agoraphobia	-.15	-.36***	-.03
Duration of agoraphobia	.04	.21	.19
Intensity of agoraphobia	.26	.03	-.04
Age at onset	-.27	-.37**	-.07

*$p \leq .05$
**$p \leq .01$
***$p \leq .001$

Note: n for correlations with presence of agoraphobia = 83 (agoraphobic and non-agoraphobic S's); n for correlations with duration, intensity, and age at onset = 35 (agoraphobic S's only).

tension within the ill subject. Hypothesis 3 appears to be rejected: the strength of the association appears to reflect the anxious context of the agoraphobic sufferer.

> Hypothesis 4: There are no statistically significant relationships between the incidence, duration, severity, and age at onset of agoraphobia in the female and the husband's perceived level of individual tension.

The correlation coefficient between agoraphobia in the home and the husband's tension level failed to achieve significance (r = -.15). Among the 35 husbands married to agoraphobics ("spouses") the highest correlations with husband's tension levels were between age at onset of agoraphobia (r = -.27) and intensity of agoraphobia (r = .26). However, the correlations were not significant at the .05 level. Hypothesis 4 cannot be rejected in this study: there does not appear to be a relationship between agoraphobia and the tension of the husband. Given the size of the correlations, further research is needed to examine possible negative relationships between husband tension and both intensity of the wife's agoraphobia and the age of onset.

> Hypothesis 5: There are no statistically significant relationships between the incidence, duration, severity, and age at onset of agoraphobia in the wife and her education level.

Table XIV details the correlations between the agoraphobia variables and wive's education. As can be seen, the presence of agoraphobia was significantly related to the wife's education (r = -.44). This negative association was significant beyond the .001 level indicating that less formally educated wives are more likely to suffer from agoraphobia than more formally educated wives and vice versa.

No causality can be inferred at this point, however. Direction of

association may plausibly flow in either direction. In other words, it is unclear whether the presence of agoraphobia keeps women from participating in the external context of the formal academic environment or whether coping skills tend to be more prevalent among more educated women. It is also possible that the correlation is an artifact of sampling methodology; i.e., there was a noticeably higher degree of education present among the control samples. (See Table IX.) Bearing out this possibility are the negligible associations found for the last three measures of agoraphobia (which utilize information from agoraphobic wives only). Given this possibility, it would be problematic to reject Hypothesis 5 prior to more research on this point.

> Hypothesis 6: There are no statistically significant relationships between the incidence, duration, severity, and age at onset of agoraphobia in the wife and her husband's education level.

Table XIV also reveals a significant negative relationship between the presence of agoraphobia in the home and the husband's educational level ($r = -.36$). Unlike the case with the wives, however, there was also a significant negative association between formal education and another measure of agoraphobia: age at onset ($r = -.37$). Since this correlation obtains from the agoraphobic couples only, it cannot be an artifact of the sampling. The association appears to suggest that the more highly educated the husband, the earlier the agoraphobia seems to manifest itself in his wife. The nature of these finding is unclear but the null hypothesis appears to have been rejected with these data.

> Hypothesis 7: There are no statistically significant relationships between the incidence, duration, severity, and age at onset of agoraphobia in the wife and her employment.

Finally, Table XIV presents data on the correlation between measures of agoraphobia and the wives' employment. As can be seen, none of the associations reach statistical significance. The differences between husbands' and wives' report of the same phenomenon (employment of the wife) probably reflect differences in definitions of what constitutes employment (work inside the home, for example).

Hypothesis 8: There are no statistically significant relationships between the incidence, duration, severity, and age at onset of agoraphobia in the wife and her perception of the family coping stratagems of:

a. Confidence in family problem solving
b. Reframing of family problems
c. Family passivity
d. Church/religious activities
e. Extended family
f. Friends
g. Neighbors
h. Community

Table XV displays the correlations between the agoraphobia items and the F-Cope's Internal Family Coping Patterns which reflect a family's behavioral strategies for handling problems through confidence in their problem-solving ability, reframing the problem, or assuming a passive posture. Two of the four agoraphobic measures (presence and duration) indicated a conflicting relationship with a female agoraphobic's perception of mastery in dealing with difficulties.

The correlation with presence of agoraphobia (r = -.19) indicated that the very presence of agoraphobia has a negative impact on the female agoraphobic's appraisal of the family's ability to deal with problems. This finding is consistent with the low self-esteem that appears thematic to this agoraphobic sample. The correlation with duration of agoraphobia, on the other hand, (r = .28) seemed to support

TABLE XV

CORRELATIONS BETWEEN AGORAPHOBIC CHARACTERISTICS AND INTERNAL FAMILY COPING PATTERNS

	Internal Family Coping Patterns		
	Confidence in Problem Solving	Reframing Family Problems	Family Passivity
Females			
Presence of agoraphobia	-.19*	-.15	.24**
Duration of agoraphobia	.28*	.08	-.03
Intensity of agoraphobia	.06	-.32*	-.01
Age at onset	.06	.22	.04
Males			
Presence of agoraphobia	.08	.13	.13
Duration of agoraphobia	.17	-.21	.38**
Intensity of agoraphobia	.09	-.11	.17
Age at onset	.33*	.31	-.06

*$p \leq .05$
**$p \leq .01$
***$p \leq .001$

Note: n for correlations with presence of agoraphobia = 83 (agoraphobic and non-agoraphobic S's); n for correlations with duration, intensity, and age at onset = 35 (agoraphobic S's only).

the assertion that the initial loss of confidence in handling problems, which occurs at agoraphobic onset, diminishes with the passing of time. That these subjects felt they were regaining confidence, may be a function of the sampling frame. The correlation between confidence and duration may well be a reflection of the therapeutic effects of the individual and group therapy inherent in the Agoraphobic Recovery Program in which they have been involved. Further investigation might control for the effects of Agoraphobia Recovery-type programs by pre-test, post-test methodologies.

The four items in the "Reframing Family Problems" subscale related to the family's perceptual orientation towards stressful experiences -- whether they viewed change positively, negatively, or neutrally. Table XV indicates no relationship between reframing family problems and three of the agoraphobic items (presence, duration, and age at onset). However, the relationship between the intensity of the malady and the agoraphobic's tendency to perceive a reframing of family problems produced a significant negative coefficient ($r = -.32$). This association portrayed agoraphobics within this sample as tending to view problems and difficulties through a negative lens with increased levels of agoraphobic intensity.

Table XV also reveals that the presence of agoraphobia correlated significantly with female agoraphobics' tendency to reflect passive behaviors such as avoidance responses based on a lack of confidence in their ability to alter the outcome. This may reflect the immobilizing effects of agoraphobia and feelings of futility.

Among the agoraphobic subsample ($n = 35$), however, the correlations between family passivity and agoraphobic duration, intensity, and age at

onset failed to achieve statistical significance. Thus, the passive behaviors varied between agoraphobic and non-agoraphobic women but not along continuums of duration, intensity, and age at onset of the disease.

The four items contained in the "Church Religious Resources" subscale reflected the family's involvement with religious activities -- i.e. attending church services, seeking advice from a minister and having faith in God when they face family problems. These coefficients are reported in Table XVI. As can be seen, the correlations failed to reflect any association between the agoraphobic items and family's utilization of religious resources in coping with their problems.

Table XVI presents the results of the correlations between variables of agoraphobia and the tendency to elicit support by communicating with and doing things with relatives. As indicated by the low correlational coefficients, there appeared to be no relationship between agoraphobia and seeking support from the extended family.

A significant negative association was evident between the presence of agoraphobia and the tendency to elicit support by communicating with and doing things with friends and obtaining their support ($r = -.39$). The presence of agoraphobia, within this sample, appeared to preclude the use of friends to obtain support. There was a significant negative association between age at onset and the utilization of friends for support ($r = -.29$). This may indicate that the tendency towards isolationism in handling difficulties (revealed in the first correlation), was exacerbated by the age at which the malady manifests itself.

Table XVI also records the problem-solving behavior which

TABLE XVI

CORRELATIONS BETWEEN AGORAPHOBIC CHARACTERISTICS AND EXTERNAL FAMILY COPING PATTERNS

	External Family Coping Patterns				
	Religious Resources	Extended Family	Friends	Neighbors	Community Resources
Females					
Presence	-.14	-.17	-.39***	-.35***	-.14
Duration	.02	-.04	.06	-.07	-.19
Intensity	.16	.18	.27	.15	.25
Age at onset	.07	-.17	-.29**	.00	.02
Males					
Presence	-.17	-.20*	-.16	-.14	-.02
Duration	.03	.17	-.12	-.13	.08
Intensity	-.05	.01	-.32*	-.28	.14
Age at onset	.17	.02	.27	.47***	-.09

*$p \leq .05$
**$p \leq .01$
***$p \leq .001$

Note: n for correlations with presence of agoraphobia = 83 (agoraphobic and non-agoraphobic S's); n for correlations with duration, intensity, and age at onset = 35 (agoraphobic S's only).

emphasized receiving help and support from neighbors and its correlation with variables of agoraphobia. There appeared to be a significant negative relationship between the presence of agoraphobia and utilizing neighbors for help and support (r = -.35). Significant at the .001 level, this negative coefficient implies an aversion by agoraphobics to seeking support and help from neighbors. No significant correlation was indicated between seeking support from neighbors and duration, intensity, and age of agoraphobic onset. The rejection of neighbors was marked between agoraphobic and non-agoraphobic wives but did not appear to vary according to the duration, intensity, and age at onset of the illness. Perhaps any degree of agoraphobia is sufficient for the couple to prefer isolation.

The Community Resources subscale measures a behavior which emphasizes the utilization of community agencies and programs such as counseling services and physicians. The association between intensity of agoraphobia and the utilization of community resources (r = .25) was the strongest relationship but failed to achieve statistical significance. The probability of this relationship, however, was close to the .05 level ($p < .07$). It is tempting to speculate that the more distressing the agoraphobia, the more likely one is to seek assistance from community resources. Yet, the apparent reluctance to seek help may be a function of the sampling frame. With so little known about agoraphobia among professionals in the helping professions, agoraphobics have been misdiagnosed and frustrated in their attempts to find professional assistance. Common among agoraphobics is a sense of frustration and sometimes anger towards physicians, psychologists, counselors, etc.

Hypothesis 5, therefore, produced a mixture of significant and non-significant findings regarding the agoraphobic's utilization of external family assistance. It is not clear if the null hypothesis should be accepted or rejected. However, the negative associations of the presence of agoraphobia with confidence, seeking assistance from friends and neighbors and the positive association with family passivity seem to suggest a picture of isolationism and caution in social interaction. Thus, hypothesis 5 is tentatively rejected bearing future investigation.

Hypothesis 9: There are no statistically significant relationships between the incidence, duration, severity, and age at onset of agoraphobia in the wife and her husband's perception of the family coping stratagems of:

a. Confidence in family problem solving
b. Reframing of family problems
c. Family passivity
d. Church/religious activities
e. Extended family
f. Friends
g. Neighbors
h. Community

Tables XV and XV also display the variables of agoraphobia and their relative association with the husband's measurement of the family's ability to cope with difficulties. Unlike the pattern with the female agoraphobics and non-agoraphobics, no clear picture emerged from an examination of the tables for associations between agoraphobia in the home and husband's perception of family coping strategies. There was only one significant correlation between the presence of agoraphobia in the home and the husband's report of the family's coping patterns. This relationship, between presence of agoraphobia and the male respondent's tendency to view the family as eliciting support by communicating with

and doing things with relatives (r = -.20), seems to indicate a perceived reluctance of the ill family to rely on relatives when problems occur.

When considering only those husbands who live with an agoraphobic (n = 35), several significant relationships could be seen between duration, intensity, and age at onset of the wive's illness. Again, however, no clear-cut pattern of husband responses emerged.

The wive's agoraphobia did not appear to have intruded upon the husbands' perception of family confidence in managing difficulties. (See Table XV.) In fact, a correlation at the .05 level between age of onset and confidence in handling problems (r = .33) seems to indicate that the later in life agoraphobia manifests itself, the stronger the male registers family confidence in problem solving.

There were no significant associations between agoraphobia items and the couple's tendency to reframe family problems. The illness of their wives did not appear to be substantially changing the way husbands perceive family problems.

The results of the correlations between family passivity and the agoraphobic items revealed a statistically significant relationship between the amount of time a wife had agoraphobia and her husband's tendency to identify family problems as being dealt with passively (r = .38). This association was significant beyond the .01 level and may reflect something of the impact of agoraphobia on the family system. It may indicate that when the malady persists over a period of time, the non-agoraphobic spouse feels helpless to solve the problem. Also, the tenacious nature of the illness may be such that when the wife does not recover after a "sufficient" period of time, the husband interprets her

response to the illness as passive.

None of the items contained in the Church and Religious Resources subscale (see Table XVI) were significantly associated with the agoraphobic items. There was no apparent relationship between the duration, intensity, and age at onset of agoraphobia and the family's involvement with religious activities.

A significant association was evident in the negative coefficient between intensity of the wife's agoraphobia and husband's report of the family's reliance on friends (r = -.32). The apparent isolationist posture of the agoraphobic couple regarding friends was also reflected in the non-agoraphobic husband's perception of problem-solving behavior.

Whereas the agoraphobic subjects themselves reported a reluctance of the family to rely on neighbors for help, the non-agoraphobic husbands did not appear to share that perception. The more advanced the age of the wife at onset, the more willing the husband believed the family was to welcome assistance from neighbors (r = .47).

The Community Resources subscale measures a behavior which emphasizes the utilization of community agencies and programs such as counseling services and physicians. Evident in the correlational values (Table XVI), no significant relationships were reported by husbands.

Hypothesis 6 produced a scattering of significant and non-significant correlations. While an evaluation would be inconclusive at this time, it subjectively appeared that, overall, the null hypothesis should not be rejected: there were no clear grounds for concluding that the incidence, duration, severity, and age at onset of the wife's agoraphobia was related to the husband's perception of the family's coping patterns.

Hypothesis 10: There are no statistically significant relationships between the incidence, duration, severity, and age at onset of agoraphobia in the wife and her perceptions of the family environment elements of:

a. Cohesion
b. Expressiveness
c. Conflict
d. Independence
e. Intellectual/cultural orientation
f. Activity orientation
g. Moral/religious emphasis

Correlations between the Moos FES scale of family cohesion and the variables of agoraphobia (presence, duration, intensity, and age at onset) are reported in Table XVII. The strength of the negative association between presence of agoraphobia and family cohesion is reflected in the correlational value of -.47 ($p < .001$). The presence of agoraphobia appears to be accompanied by a diminished degree of commitment, help, and support that family members provide for one another.

The relationships of the four measures of agoraphobia to expressiveness within the family system are also reported in Table XVII. The presence of the malady appears to have an inhibiting effect on family members acting openly with each other ($r = -.28$). The continued presence of the agoraphobia over time seems to further restrict spontaneity and the free expression of feelings ($r = -.34$). From the agoraphobic female's perspective, the family environment is characterized by insufficient communication between family members.

As indicated by the correlation of .22, the presence of agoraphobia bears a strong relationship with the amount of openly expressed anger, aggression, and conflict among family members. No association is evident between duration and intensity of agoraphobia and perceived conflict

TABLE XVII

CORRELATIONS BETWEEN AGORAPHOBIC CHARACTERISTICS AND THE FAMILY ENVIRONMENT RELATIONSHIP SUBSCALE

	Relationship Dimensions		
	Cohesion	Expressiveness	Conflict
Females			
Presence	-.47***	-.28**	.22**
Duration	.16	-.34**	.04
Intensity	.02	.15	.21
Age at onset	.15	.14	-.28*
Males			
Presence	-.29**	-.17	.03
Duration	.05	-.09	.02
Intensity	.09	-.23	.15
Age at onset	.06	.19	-.13

*$p \leq .05$
**$p \leq .01$
***$p \leq .001$

Note: n for correlations with presence of agoraphobia = 83 (agoraphobic and non-agoraphobic S's); n for correlations with duration, intensity, and age at onset = 35 (agoraphobic S's only).

Hypothesis 10: There are no statistically significant relationships between the incidence, duration, severity, and age at onset of agoraphobia in the wife and her perceptions of the family environment elements of:

a. Cohesion
b. Expressiveness
c. Conflict
d. Independence
e. Intellectual/cultural orientation
f. Activity orientation
g. Moral/religious emphasis

Correlations between the Moos FES scale of family cohesion and the variables of agoraphobia (presence, duration, intensity, and age at onset) are reported in Table XVII. The strength of the negative association between presence of agoraphobia and family cohesion is reflected in the correlational value of -.47 ($p < .001$). The presence of agoraphobia appears to be accompanied by a diminished degree of commitment, help, and support that family members provide for one another.

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As indicated by the correlation of .22, the presence of agoraphobia bears a strong relationship with the amount of openly expressed anger, aggression, and conflict among family members. No association is evident between duration and intensity of agoraphobia and perceived conflict

between family members. By way of contrast, the association between age at onset and conflict indicates a negative relationship (r = -.28). The implication may be that the older a subject is at agoraphobic onset, the less conflict is represented as present in the family system.

The extent to which family members are independent (i.e., are assertive, self-sufficient, and make their own decision) is correlated with the agoraphobic items in Table XVIII. Although the presence of agoraphobia, per se, is not related to family independence, significant associations were reflected in both intensity of agoraphobia and the age of onset. The association between the intensity of agoraphobia and independence resulted in a negative correlation (r = -.36). With agoraphobic symptoms intensified, the ill wife reports diminished levels of self-sufficiency and independence within the family. The association between age at onset and the measure of independence was significant and positive (r = .33). It appears that, if the agoraphobia does not manifest itself until later in life, the perceived level of self-sufficiency also increases. To some extent, it appears that the older the wife is when the agoraphobic symptoms become manifest, the less debilitating the illness and the more control the family retains.

The extent to which activities (such as school and work) are cast into an achievement-oriented or competitive framework was correlated with the agoraphobia variables. Table XVIII reflects no level of statistical significance for any of the four measures of agoraphobia when correlated with achievement.

When correlated with the presence of agoraphobia, the ill subjects indicated a negative relationship with Intellectual-Cultural Orientation (r = -.22). Seemingly, this value indicates diminished degree of

TABLE XVIII

CORRELATIONS BETWEEN AGORAPHOBIC CHARACTERISTICS AND THE FAMILY ENVIRONMENT "PERSONAL GROWTH" SUBSCALE

	Personal Growth Dimensions				
	Independence	Achievement Orientation	Intellectual Cultural Orientation	Active	Moral Religious Emphasis
Females					
Presence	.03	.12	-.22*	-.40***	-.25**
Duration	-.01	.23	.01	-.14	.12
Intensity	-.36*	-.09	-.26	-.18	.07
Age at onset	.33*	.09	.10	.01	.11
Males					
Presence	-.03	-.06	-.23*	-.26**	-.34***
Duration	.04	.05	-.10	-.02	.04
Intensity	-.21	.21	-.32**	-.20	-.28
Age at onset	.16	.01	.24	.35**	.27

*$p \leq .05$
**$p \leq .01$
***$p \leq .001$

Note: n for correlations with presence of agoraphobia = 83 (agoraphobic and non-agoraphobic S's); n for correlations with duration, intensity, and age at onset = 35 (agoraphobic S's only).

interest in political, social, intellectual and cultural activities. The question must be raised as to the interpretation of this correlational value. Caution should be exercised before interpreting it as lack of intellectual-cultural orientation when, in fact, it may well reflect the often immobilizing nature of the agoraphobia.

When the items on agoraphobia were measured against the extent of participation in social and recreational activities (Active-recreational Orientation), the presence of agoraphobia in the female resulted in a relationship significant at the .001 level ($r = -.40$). The socially limiting nature of agoraphobia is probably being measured rather than an inherent dislike of social and recreational events.

When the degree of emphasis on ethical and religious issues and values was measured with the items on agoraphobia, a negative correlational value emerged ($r = -.25$). The other three agoraphobia items were not significantly related to Moral/religious Emphasis.

As Table XIX indicates, the correlation between the Organization subscale and the presence of agoraphobia was negative and significant ($r = -.25$). Overall, wives perceived their family system as less than organized. The three other agoraphobia items failed to yield significant associations with organization.

Table XIX also presents the correlational values for the measurement of agoraphobia with items of control. As can be seen, there were no significant associations.

In sum, presence of agoraphobia was significantly associated with 7 of the 10 FES scales. There were also significant associations between the other measures of agoraphobia (duration, intensity, and age at onset) for the 35 agoraphobic wives. In light of the number and strength of

TABLE XIX

CORRELATIONS BETWEEN AGORAPHOBIC CHARACTERISTICS AND THE FAMILY ENVIRONMENT "SYSTEM MAINTENANCE DIMENSION" SUBSCALE

	System Maintenance	
	Organization	Control
Females		
Presence of agoraphobia	-.25**	.10
Duration of the agoraphobia	.14	.09
Intensity of the agoraphobia	.06	.05
Age at agoraphobic onset	.06	.06
Males		
Presence of agoraphobia	-.25**	-.01
Duration of agoraphobia	-.05	-.17
Intensity of the agoraphobia	-.13	-.12
Age at agoraphobic onset	.05	.05

*$p \leq .05$
**$p \leq .01$
***$p \leq .001$

Note: n for correlations with presence of agoraphobia = 83 (agoraphobic and non-agoraphobic S's); n for correlations with duration, intensity, and age at onset = 35 (agoraphobic S's only).

these associations, it appears that the null hypothesis stated in Hypothesis 7 must be rejected.

Hypothesis 8: There are no statistically significant relationships between the incidence and duration of living with an agoraphobic wife and the severity of her illness and the husband's perception of the family environment elements of:

a. Cohesion
b. Expressiveness
c. Conflict
d. Independence
e. Intellectual/cultural orientation
f. Activity orientation
g. Moral/religious emphasis
h. Organization
i. Control

Husbands' report data in Table XVII present the correlations between family cohesion and the agoraphobia variables (presence, duration, intensity, and age at onset). There was a significant negative association between the presence of agoraphobia and the sense of commitment, help, and support that family members provide for one another ($r = -.29$). The other associations were non-significant.

The correlation of the agoraphobic variables with the Expressiveness subscale failed to reach a level of statistical significance. The non-agoraphobic husbands' perception of the level of expressiveness within the family system seems to be at variance with the values registered by their agoraphobic spouses. The well husbands do not appear to share their ill spouses' perception of diminished levels of expressiveness between family members.

The results of the correlations between the items of agoraphobia and conflict within the family system are also recorded in Table XVII. The low correlational values of the husband's perception of conflict among family members fails to reach statistical significance.

The extent to which the non-agoraphobic male perceives family members as assertive, self-sufficient and make their own decisions (Independence subscale) is correlated with agoraphobic items and reported in Table XVIII.

The extent to which activities (such as school and work) are cast into an achievement-oriented or competitive framework was correlated with the agoraphobia variables. Table XVIII reflects no level of statistical significance for any of the four measures of agoraphobia when measured with achievement.

When the items measuring the intellectual-cultural orientation were correlated with the presence of agoraphobia in the female, non-agoraphobic husbands yielded negative coefficients with presence of agoraphobia ($\underline{r}$ = -.23) and intensity of agoraphobia ($\underline{r}$ = -.32). As was discussed earlier, these values seemingly indicate minimal interest in political, social, intellectual, and cultural activities. To reiterate a caution offered earlier in this chapter, care should be exercised before interpreting it as lack of intellectual-cultural orientation when, in fact, it may well reflect the inability to participate in these activities due to the immobilizing nature of the agoraphobia.

When the items on agoraphobia were measured against the extent of participation in social and recreational activities, the presence of agoraphobia in the female resulted in a significant value ($\underline{r}$ = -.26). It may be that the socially limiting nature of agoraphobia is being measured rather than an inherent dislike of social and recreational events.

When the degree of emphasis on ethical and religious issues and values was correlated with the items on agoraphobia, a negative value emerged ($\underline{r}$ = -.34). Moral-religious emphases as measured by such items

as: "Family members have strict ideas about what is right and wrong," "The Bible is a very important book in our home," and "We believe there are some things you just have to take on faith" were not deemed important.

Table XIX presents the data on the correlation between items on agoraphobia and the husbands' measure of family organization. Overall, the husbands of agoraphobic wives ("spouses") perceived the family environment as less organized than the control husbands ($r = -.25$). Agreement between the husbands and wives is reflected in the presence of identical correlation values ($r = -.25$) when responses to agoraphobic items were measured with items on family organization.

The correlations of the non-agoraphobic husbands' responses to the Control subscale and the agoraphobia items were non-significant. This was similar to the results for wives.

Overall, the results related to Hypothesis 8 (husbands' perceptions) were not as clear as the results related to Hypothesis 7 (wives' perceptions). Still, half of the 10 associations between presence of agoraphobia and the FES subscales were significant with some significant associations between other measures of agoraphobia and FES subscales. If the null hypothesis can't be convincingly rejected, there appears to be grounds for casting serious doubt on the hypothesis.

Conclusions

In summary, this chapter has presented the results of the data in quantitative terms. This inquiry into the family environments in tandem with the female agoraphobia generated statistically significant correlations on several scales with both male and female measures.

Ostensibly, there appears to be a statistically significant relationship between agoraphobia (especially the presence of agoraphobia, per se) and scale items and other criterion variables related to perceptions of the family environment.

In the next chapter, key variables are presented from a qualitative perspective. The data presented utilize the verbatim contents of in-depth interviews of the four agoraphobic couples.

CHAPTER VI

SUMMARY AND CONCLUSIONS

Agoraphobia is a particularly incapacitating malady with an often intractable behavioral disorder. Though until recently thought to afflict only a small population, agoraphobia has emerged as a far more prevalent health problem. Estimates project a frequency of approximately 77 per 1000 population. The proportion of psychiatric patients diagnosed as phobic constitute 2 to 3% and the majority of these are agoraphobic. The intractable nature of the malady is such that a significant segment of individuals suffering from agoraphobia reported no improvement over time and an even larger group reported their condition got worse.

It is generally agreed that agoraphobia is very uncommon in childhood. With an approximate mean of 28 years of age at onset, it is likely the illness will occur within a marital context. The debilitating complexion of the malady is bound to take a toll on the family system or members within the immediate environment. Thus, to visualize the illness in a linear, cause-and-effect manner seems inappropriate. Rather, it can be conceived as a behavioral phenomena affecting and perhaps disrupting all components in an agoraphobe's familial environment. In comparison to the numerous studies that have been conducted on the etiological and treatment aspects of the malady, research into the family system appears scant.

Summary of the Results

The purpose of this study was to research the family context of recovering agoraphobics. An attempt was made to pay particular attention not only to the environment of the family system surrounding the agoraphobia but that system's coping strategies for managing family problems.

This research project possessed both qualitative and quantitative components. The initial qualitative step consisted of in-depth interviews designed to obtain deeper insights into the agoraphobic's familial system. Two agoraphobics females, an agoraphobic male and their spouses were interviewed from October, 1983 through January, 1984. A fourth female was interviewed but her husband did not follow through on his expressed willingness to participate. The focus of the interviews was on the impact of the agoraphobia on the marital and family dynamics.

Information provided by the interviews served as a guideline for the construction of a data-collection instrument on agoraphobia. Predicated on the expressed and perceived needs of agoraphobes and their spouses, a questionnaire was designed to include the items on Rosenberg's and Osgood's self-esteem scales; Moos Family Environment Scale; F-Copes by McCubbin, Larson and Olson: and case studies characterizing agoraphobic behavior.

The questionnaire provided the means for data collection. Information was elicited from subjects diagnosed as agoraphobic who had recently completed or were currently participating in an Agoraphobic Recovery program. Thirty-five agoraphobic females responded to the

questionnaire. The control sample was drawn from parents with children enrolled in Oklahoma State University's Child Development Laboratory or a Tulsa pre-school. The quantitative results of the 149 questionnaires were coded and subjected to Pearson correlations to assess the strength of the association between agoraphobia and items of self-esteem, coping patterns, and the family environment.

The statistical analysis of the research data yielded results which did not support the assertions of the eight hypotheses stated in the null form. The results of Pearson correlations established significant correlation coefficients between the Rosenberg and Osgood scales and agoraphobia, supporting the prevalence of self-doubt among agoraphobics. Statistically significant interactions resulted when agoraphobia was correlated with certain F-Cope subscales: Confidence in Problem Solving, Reframing Family Problems, Family Passivity, Friends and Neighbors. Most of these correlational values were negative and implied a general secretiveness within agoraphobic families and a reluctance to rely on outside resources when handling family difficulties. Further, strong measures of association resulted from correlating agoraphobia with FES subscales. Only two of the ten subscales (Control and Religious Orientation) failed to yield some significance beyond the .05 level. Otherwise, the spouses manifested general agreement on their family environment as to the lower levels of family organization, cohesion, intellectual-cultural orientation, moral-religious emphasis and overall level of involvement in social and recreational activities.

Conclusions

The study was implemented in order to investigate the family

environment of agoraphobics. Within the framework of the assumptions and limitations of the present study, and based on the findings obtained from the investigation, the following conclusions appear to be justified:

1) Serious erosion appears in the self-esteem of the female agoraphobic. In general, they are characterized by marked self-doubt coupled with feelings of pessimism and lack of confidence. The non-agoraphobic husbands of these women do not share this dim view of self-worth.

2) The agoraphobia in females is characteristically accompanied by increased amounts of tension within the ill subject.

3) Providing agoraphobics with a 15-week treatment-recovery experience does not appear to alleviate the tendency to remain secretive about their disorder. The pattern appears for agoraphobic families to "suffer in silence."

4) Kinship ties in the family environment appear to lack integration and be weakened by: a) low degree of help and support between family members, b) reduced levels of spontaneity in the expression of feelings, and c) openly expressed anger and conflict.

5) Both agoraphobics and their spouses feel socially immobilized with reduced levels of participation in social/recreational activities.

6) Agoraphobic families in general are loosely structured systems

apparently lacking clear organization.

Suggestions for Further Research

The present study has left many questions unanswered because of time constraints and logistical limitations inherent in this particular investigation. For example, methodological problems precluded a truely representative portrait of the family environment, which would have necessitated information gathered from all persons in the immediate and extended familial context. The conclusions presented about the family environments surrounding agoraphobia are, in this study, merely the husbands' and wives' perceptions of the family system. Future studies might give more attention to the inclusion of adolescent children and the extended family. This is not to imply that the partial measures of the present investigation are not accurate, but to argue that complete measures may provide a fuller representation.

Second, the sampling did not reflect heterogeneity. With the exception of three respondents, all the agoraphobics were female. The intention at the outset of the investigation was to research an equal number of agoraphobic males and females. In view of the small number of male agoraphobics who responded, they were disregarded in the data. The presence of male agoraphobics may well have produced a different set of data. These data were provided by a relatively homogeneous sample, with all of them having experienced group and individual treatment for their agoraphobia. It seems reasonable that a pre-treatment sample would perhaps yield a different set of data.

Finally, the agoraphobic subject requires careful evaluation by a mental health specialist acquainted with agoraphobia. Correct

information and treatment are imperative for the phobic subject to maintain any sense of equilibrium. Of equal importance is the treatment of the family system impacted by the malady. The task of this study was merely to assess the family environment and elucidate the conditions under which the agoraphobia generally occurs.

Emerging from this particular research were several issues, which were not among the initial objectives of the present study, but which may manifest potential for future investigations into the impact of agoraphobia on the family system. Central among these are several apparent concerns, which could be profitably addressed.

1) Both within the literature, and within this particular study, children have received little or no attention. Yet, the impact of agoraphobia is not limited to the healthy spouse but is likely to have a significant impact on some of the less powerful family members; i.e., children. But, the children are not only affected by, but may effect, the malady. Thus, the role of children in the process and perpetuation of the malady appears to hold promise for further investigation.

2) The parental system of the diagnosed agoraphobic bears closer exploration. An element present in two of the four in-depth interviews was the possible enmeshment of the agoraphobic in the parental system. In the future, family researchers may wish to explore the parental system of the agoraphobic as both sustaining and maintaining the dependence of the adult agoraphobe.

3) For the most part, the agoraphobics in this sample were married to men willing to accompany them to therapy over a period of

fifteen weeks. However, the data collection realized eight agoraphobic females whose husbands were unwilling to participate in this project. Similar responses surfaced in the in-depth interviews where one husband refused to participate. Further research may well compare agoraphobia as it occurs in both supportive and non-supportive spousal systems.

4) The literature on agoraphobia appears to manifest a disproportionate concern with the female agoraphobe. Questions remain to be answered as to whether this preponderance of concern for females accurately portrays the agoraphobic epidemiology or is but an artifact of the culture.

It is believed, therefore, that continuation of research into the network and kinship structure surrounding agoraphobia is of crucial importance. It should be given high priority by researchers of the family.

BIBLIOGRAPHY

Abrahm, H. (1972). The psychology of chronic illness. Journal of Chronic Diseases, 25, 659-664.

Ackerman, N., & Sobel, R. (1950). Family diagnosis: An approach to the preschool child. American Journal of Orthopsychiatry, 4, 744-754.

Agoraphobics and how they fear [Interview with Robert Ingram]. (1981, October). Tulsa World.

Agras, S., Sylvester, D., & Oliveau, D. (1969). The epidemiology of common fears and phobias. Comparative Psychiatry, 1, 151-156.

Agulnik, P. (1970). The spouse of the phobic patient. British Journal of Psychiatry, 117, 59-67.

American Home Economics Association. (1959). Home economics: New directions. Washington, DC: Author.

American Home Economics Association. (1974). Home economics: New directions II: A statement of philosophy and objectives. Washington, DC: Author.

American Psychiatric Association. (1980). Diagnostic and statistical manual of mental disorders (3rd ed.) Washington, DC: Author.

Andrews, J. D. W. (1966). Psychotherapy of phobias. Psychological Bulletin, 66, 455-481.

Anthony, J. (1969). The mutative impact on family life of serious mental and physical illness in a parent. Canadian Psychiatric Association Journal, 14, 433-453.

Arey, S., & Warheit, G. (1980). Psychosocial costs of living with psychologically disturbed family members. In L. Robins, P. Clayton, & J. Wing, (Eds.), The social consequences of psychiatric illness. London: Brunner Maezel.

Asso, D., & Beech, H. R. (1975). Susceptibility to the acquisition of a conditioned response in relation to the menstrual cycle. Journal of Psychomatic Research, 19, 337-344.

Barrett, J., Jr., Kuriansky, J., & Gurland, B. (1972). Community tenure following emergency discharge, American Journal of Psychiatry, 128, 958-964.

Bateson, G., & Jackson, D. (1956). Towards a theory of schizophrenia. Behavioral Science, 1, 251-264.

Bateson, G., Jackson, D., Haley, J., & Weakland, J. (1956). Towards a theory of schizophrenia. Behavioral Science, 1, 251-264.

Benedikt, V. (1870). Uber Platzschindel. Allgemeine Weiner Medizinische Zeitung, 15, 488.

Bergner, R. M. (1977). The marital system of the hysterical individual. Family Process, 16, 85-95.

Berman, E. (1973). Scapegoat. Ann Arbor: University of Michigan Press.

Bertalanaffy, Ludwig von, (1934). Modern theories of development: An introduction to theoretical biology. London: Oxford University Press.

Blacher, R. (1970). Loss of internal organs. In B. Schoenberg, A. Carr, D. Peretz, & A. Kutscher (Eds.), Loss and grief: Psychological management in medical practice (pp. 132-139). New York: Columbia University Press.

Brown, M., & Paolucci, B. (1979). Home economics: A definition. (Available from the American Home Economics Association, 2010 Massachusetts Ave., NW, Washington, DC, 20036-1028)

Budewig, C., (1964). Home economics in historical perspective. In American Home Economics Association (Ed.), The field of home economics (pp. 5-17). (Available from AHEA, 2010 Massachusetts Ave., Washington, DC, 20036-1028)

Buglass, D., Clarke, J., Henderson, A., Kreitman, N., & Presley, A. (1977). A study of agoraphobic housewives. Psychological Medicine, 7, 73-86.

Burge, S., & Figley, C. (1982). The social support scale. In C. Figley & H. McCubbin (Eds.), Stress and the family II: Coping with catastrophe (p. 11). New York: Brunner/Mazel.

Burns, L. E., & Thorpe, G. L. (1977). The epidemiology of fears and phobias with particular reference to the national survey of agoraphobics. Journal of International Medical Research, 5, 1-7. (supplement)

Carstairs, G. (1959). The social limits of eccentricity: An English study. In M. Opler, (Ed.), Culture and mental health: Cross-cultural studies. New York: Macmillan.

Chambless D. L., & Goldstein, A. J. (Eds.) (1982). Agoraphobia: Multiple perspectives on theory and treatment. New York: Wiley.

Christopherson, V. (1968). Role modifications of the disabled male. American Journal of Nursing, 68, 290-293.

Chodoff, P. (1962). Understanding and management of the chronically ill patient. American Practitioner, 13, 136-144.

Clausen, J. (1959, September). The marital relationship antecedent to hospitalization of a spouse for mental illness. Paper presented at the meeting of the American Sociological Association, Chicago, IL.

Clausen, J., & Yarrow, M. (1955). The impact of mental illness on the family. Journal of Social Issues, 11, 3-5.

Cordes, E. (1871). Die Platzangst (Agoraphobie): Symptom einer Erschopflungsparese. Archiv fur Psychiatrie und Nervenkrankheiten, 3, 521-524.

Crabtree, B. (1979). Comments on the paper, "Home economics: A definition." In Home economics: A definition (pp. 125-136). (Available from AHEA, 2010 Massachusetts Ave. NW, Washington, DC, 20036-1028)

Crowell, Thomas (Ed.). (1970). Bulfinch's Mythology. New York: Thomas Y. Crowell.

Dixon, J. M., deMonchaux, C., & Sandler. (1957). Patterns of anxiety: The phobias. British Journal of Medical Psychology, 3, 34-44.

Emmelkamp, P. (1979). The behavioral study of clinical phobia. In M. Hersen, R. M. Eisler, & P. M. Miller (Eds.), Progress in behavior modification (Vol. 8, pp. 55-125). New York: Academic Press.

Emmelkamp. P., & Kuipers, A. (1979). A follow-up study four years after treatment. British Journal of Psychiatry, 134, 352-355.

Emmelkamp. P. (1980). Agoraphobics' interpersonal problems: Their role in the effects of exposure in vivo therapy. Archives of general Psychiatry, 37, 1303-1306.

Ey, H., Bernard, P., & Brisset, C. (1974). Manuel de psychiatrie. Masson: Paris.

Figley, C., & McCubbin, H. (1983). Stress and the family: Vol. 2. Coping with catastrophe. New York: Bruner-Mazel.

Fodor, I. G. (1974). The phobic syndrome in women: Implications for treatment. In V. Franks & V. Burtle (Eds.), Women in therapy. New York: Brunner/Mazel.

Forcese, D. P., & Richer, S. (1973). Social research methods. Englewood Cliffs, NJ: Prentice-Hall.

Frampton, M. (1974). Overcoming agoraphobia: Coping with the world out side. New York: St. Martin's Press.

Freud, S. (1962). Obsessions and phobias: Their physical mechanism and their aetiology. Standard Edition (Vol. 3). London: Hogarth Press.

Freud, S. (1964). Analysis of phobia in a five-year-old boy. In J. Strachey, (Ed.), The complete works of Sigmund Freud. London: Hogarth Press.

Friedman, P., & Goldstein, J. (1974). Phobic reactions. In S. Arieti & E. G. Brodie (Eds.), American handbook of psychiatry, (2nd ed.), New York: Basic Books.

Fry, W. F. (1962). The marital context of an anxiety syndrome. Family Process, 1, 245-252.

Goffman, E. (1963). Stigma: Notes on the management of a spoiled identity. Englewood Cliffs, NJ: Prentice-Hall.

Goldstein, A., & Chambless, D. (1978). A reanalysis of agoraphobia. Behavior Therapy, 9, 47-59.

Goodstein, R., & Swift, K. (1977). Psychotherapy with phobic patients: The marriage relationship as the source of symptoms and focus of treatment. American Journal of Psychotherapy, 31, 285-292.

Grad, J., & Sainsbury, P. (1963). The effects that patients have on their families in a community care and control psychiatric services: A two year follow up. British Journal of Psychiatry, 114, 265-268.

Grant, B., Katon, W., & Beitman, B. (1983). Problems in family practice: Panic disorder. The Journal of Family Practice, 17, 907-914.

Hafner, J. (1977a). The husbands of agoraphobic women: Assortive mating or pathogenic interaction? British Journal of Psychiatry, 130, 233-239.

Hafner, J. (1977b). The husbands of agoraphobic women and their influence on treatment outcome. British Journal of Psychiatry, 131, 289-294.

Haley, J. (1982, November). The family [Interview with Maya Pines]. Psychology Today, pp. 61-69.

Hallam, R. S., & Hafner, R. J. (1978). Fears of phobic patients: Factor analyses of self-report data. Behavior Research and Therapy, 16, 1-6.

Halpern, H., Canale, J., Gant, B., & Bellamy, C. (1979). A systems-crisis approach to family treatment. Journal of Marital and Family Therapy, 87-94.

Hardy, A. B. (1976). Agoraphobia: Symptoms, causes and treatments. Menlo Park: Terrap.

Hill, R., & Hansen, D. (1962). Families in disaster. In G. Baker, & D. Chapman (Eds.), Man and society in disaster (pp. 185-221). New York: Basic Books.

Hirsch, B. (1980). Natural support systems and coping with major life changes. American Journal of Community Psychology, 8, 159-171.

Hoenig, J., & Hamilton, M. (1969). The desegregation of the mentally ill. London: Routledge & Kegan Paul.

Holm, H.J. (1982). The agoraphobic married woman and her marriage pattern. In F.W. Kaslow's (Ed.) The international book of family therapy. New York: Brunner-Mazel.

Hudson, B. (1974). The families of agoraphobics treated by behavior therapy. British Journal of Social Work, 4, 51-59.

Jackson, D. D. (1951). Family interaction, family homeostasis of some implications for conjoint family psychotherapy. In J. H. Masserman (Ed.), Science and psychoanalysis: Individual and familial dynamics. New York: Grune & Stratton.

Kaslow, F. W. (Ed.) (1982). The international book of family therapy. New York: Brunner/Mazel.

Kerlinger, F. (1973). Foundations of Behavioral Research. New York: Holt, Rinehart & Winston.

Klein, D. (1968). Psychiatric diagnosis and a typology of clinical drug effects. Pharmacologia, 13, 359-386.

Klein, D. (1975). Psychopharmacology and the borderline Patient. In J. Mack (Ed.), Borderline States in Psychiatry (pp. 75-92). New York: Grune & Stratton.

Klein, R., Dean, A., & Bodgdonoff, M. (1967). The impact of illness upon the spouse. Journal of Chronic Diseases, 20, 241-248.

Kong-Ming New, P. (1968). The support structure of heart and stroke patients. Social science and medicine, 2 185-200.

Koos, E. (1946). Families in Trouble. New York: King's Crown Press.

Koos, E. (1954). The health of Regionville: What they thought and did about it. New York: Columbia University Press.

Kreisman, D., & Joy, V. (1974). Family response to the mental illness of a relative: A review of the literature. Schizophrenia Bulletin, 10, 34-57.

Lederer, H. (1952). How the sick view their world. Journal of Social Issues. 8, 4-15.

Lewis, V., & Zeichner, A. (1960). Impact of admission to a mental hospital on the patient's family. Mental Hygeine, 44, 503-509.

Marks, I. M. (1967). Components and correlates of psychiatric questionnaires. British Journal of Medical Psychology, 4, 261-271.

Marks, I. M. (1969). Fears and phobias. New York: Academic Press.

Marks, I. M. (1970). Agoraphobic syndrome (phobic anxiety state). Archives of General Psychiatry, 23, 538-554.

Marks, I.M., & Gelder, M. G. (1966). Different ages of onset in varieties of phobia. American Journal of Psychiatry, 123, 218-221.

Marks, I. M., & Herst, E. R. (1970). A survey of 1200 agoraphobics in Britain. Social Psychiatry, 5, 16-24.

Mathews, A. M., Gelder, M. G., & Johnston, D. W. (1981). Agoraphobia: Nature and treatment. New York: Guilford Press.

McCubbin, H., Larsen, A., & Olson, D. (1982). F-Copes -- Family coping strategies. In H. McCubbin, D. Olson, A. Larsen, S. Muxen, & Wilson, Family inventories: Inventories used in a national survey of families across the family life cycle (pp. 101-120). St. Paul: University of Minnesota Press.

Melville, J. (1977). Phobias and obsessions. New York: Coward, McCann, & Geoghegan.

Mendel, J. G., & Klein, D. F. (1969). Anxiety attacks with subsequent agoraphobia. Comprehensive Psychiatry, 1, 190-195.

Miller, B., & Levis, D. (1971). The effects of varying short visual exposure time to a phobic test stimulus on subsequent avoidance behavior. Behavior Research and Therapy, 8, 17-21.

Miller, M. L. (1953). On street fear. International Journal of Psychoanalysis, 34, 232-252.

Mills, E. (1962). Living with mental illness: A study in East London. London: Routledge & Kegan Paul.

Milton, F., & Hafner, R. J. (1979). The outcome of behavior therapy for agoraphobia in relation to marital adjustment. Archives of General Psychiatry, 36, 807-811.

Moos, R. H., & Moos, B. S. (1981). Family environment scale. Palo Alto, CA: Consulting Psychologists Press.

Moos, R. H., Clayton, J., & Max, W. (1979). The social climate scales: An annotated bibliography. Palo Alto, CA: Consulting Psychologists Press.

Mullaney, J., & Tripett, C. J. (1979). Alcohol dependence and phobias: Clinical description and relevance. British Journal of Psychiatry, 135, 565-573.

Okun, B. F., & Rappaport, L. J. (1980). Working with families: An introduction to family therapy. MA: Duxbury Press.

Osgood, C., Suci, G., & Tannenbaum, P. (1957). The Measurement of Meaning. Urbana: University of Illinois Press.

Overs, R., & Healy, J. (1973). Stroke patients: Their spouses, families and the community. In Cobb (Ed.), Medical and physical aspects of disability (pp. 87-117). Springfield, IL: Charles C. Thomas.

Parsons, T., & Fox, R. (1952). Illness, therapy and the modern urban American family. In E. Jaco (Ed.), Patients, physicians and illness (Vol. 1, pp. 701-712). Glencoe, IL: Free Press.

Rabkin, J. (1972). Opinions about mental illness: A review of the literature. Psychological Bulletin, 77, 153-171.

Rapoport, R., & Rosow, D. (1966). An approach to family relationships and role performance. In B. Biddle & E. Thomas (Eds.), Role theory: Concepts and research (pp. 231-236). New York: Wiley.

Reusch, J., & Bateson, G. (1951). Communication and the social matrix of psychiatry. New York: W. W. Norton.

Rhead, C. (1969). The role of pregenital fixations in agoraphobia. Journal of Psychoanalytical Association, 17, 848-861.

Rose, C. (1959). Relatives' attitudes and mental hospitalization. Mental Hygiene, 43, 194-203.

Rutter, M., Tizzard, J., & Whitmore, K. (1968). Education, health and behavior. London: Longman.

Safilios-Rothschild, C. (1968). Deviance and mental illness in the Greek family. Family Process, 7, 100-117.

Schoenberg, B., & Senescu, R. (1970). The patient's reaction to fatal illness. In B. Schoenberg, A. Carr, D. Peretz & A. Kutscher (Eds.), Loss and grief: Psychological management in medical practice (pp. 221-237). New York: Columbia University Press.

Schwartz, C. (1956). The stigma of mental illness. Journal of Rehabilitation, 21, 7.

Selltiz, C., Jahoda, M., Deutch, M., & Cook, S. W. (1959). Research methods in social relations. New York: Holt, Rhinehart & Winston.

Shafar, S. (1976). Aspects of phobic illness: A study of 90 personal cases. British Journal of Medical Psychology, 49, 221-236.

Shapira, K., Kerr, T. A., & Roth, M. (1979). Phobias and affective illness. British Journal of Psychiatry, 117, 24-32.

Snaith, R. P. (1968). A clinical investigation of phobias. British Journal of Psychiatry, 114, 673-694.

Solyom, L. (1976). Maternal overprotection in the etiology of agoraphobia. Canadian Psychiatric Association Journal, 18, 25-32.

Solyom, L., Beck, P., Solyom, C., & Huzel, R. (1974). Some etiological factors in phobic neurosis. Canadian Psychiataric Association Journal, 18, 25-32.

Solyom, L, Silberfeld, M., & Solyom, C. (1976). Maternal overprotection in the etiology of agoraphobia. Canadian Psychiatric Association Journal, 21, 109-113.

Spiegel, J. (1957). The resolution of the role conflict within the family. Psychiatry, 20, 4-16.

Stoneall, L. (1983). Dilemmas of support: Accordion relations between families and the deinstitutionalized mentally ill. Journal of Family Issues, 4, 659-676.

Terhune, W. B. (1949). The phobic syndrome: A study of eighty-six patients with phobic reactions. Archives of Neurology and Psychiatry, 62, 162-172.

Torpey, D. M., Lawrence, G., & Measey, L. (1974). Marital interaction in agoraphobia. Journal of Clinical Psychology, 30, 351-354.

Tucker, W. I. (1956). Diagnosis and treatment of the phobic reaction. American Journal of Psychiatry, 112, 825-830.

Vignos, R., Thompson, H., & Katz (1972). Compresehsive care and psychosocial factors in rehabilitation in chronic rheumatoid arthritis: A controlled study. Journal of Chronic Disease, 15, 457-467.

Vila, J., & Beech, H. R. (1977). Vulnerability and conditioning in relation to the human menstrual cycle. British Journal of Social and Clinical Psychology, 16, 69-75.

Vila, J., & Beech, H. R. (1978). Vulnerability and defensive reactions in relations to the human menstrual cycle. British Journal of Social and Clinical Psychology, 17, 93-100.

Vincent, C. (1963). The family in health and illness: Some neglected areas. Annals of the American Academy of Political and Social Science, 346, 109-116.

Warren, C. (1983). Mental illness in the family: A comparison of husbands' and wives' definitions. Journal of Family Issues, 4, 533-558.

Waters, M., & Northover, J. (1965). Rehabilitated long-stay schizophrenics in the community. British Journal of Psychiatry, 11, 258-267.

Webster, A. (1953). The development of phobias in married women, Psychological Monographs, 112, 825-830.

Weekes, C. (1976). Simple, effective treatment of agorphobia. New York: Hawthorn Books.

Westphal, C. (1871). Eine neuropathische Erscheinung. Archiv fur Psychiatrie und Nervenkrankheiten, 3, 138-161.

Wolpe, J. (1958). Psychotherapy by reciprocal inhibition. Stanford, CA: Stanford University Press.

Yarrow, M., Clausen, J., & Robbins, P. (1955a). The social meaning of mental illness. Journal of Social Issues, 11, 33-48.

Yarrow, M., Schwartz, C. Murphy, H., & Deasy, L. (1955b). The psychological meaning of mental illness in the family. The Journal of Social Issues, 11, 12-24.

Zahn, M. (1973). Incapacity, impotence, and impairment: Their effect upon interpersonal relations. Journal of Health and Human Behavior, 14, 115-123.

Zitrin, C. M., Klein, D. F., Lindeman, D., Tobak, P., Rock, M., Kaplan, J., & Ganz, V. H. (1976). Comparison of short-term treatment of regimens in phobic patients: A preliminary report. In R. L. Spitzer & D. F. Klein (Eds.), Evaluation of psychological therapies. Baltimore: Johns Hopkins Press.

APPENDIX A

QUANTITATIVE QUESTIONNAIRE

measuring responses in the family environment

A. TO WHAT EXTENT DO YOU AGREE OR DISAGREE WITH EACH OF THE FOLLOWING STATEMENTS?

(circle your answer to the right of each question)

	STRONGLY AGREE	AGREE	DISAGREE	STRONGLY DISAGREE
1. I certainly feel useless at times	SA	A	D	SD
2. At times I think I am no good at all	SA	A	D	SD
3. On the whole, I am satisfied with myself	SA	A	D	SD
4. I feel I do not have much to be proud of	SA	A	D	SD
5. I am able to do things as well as most other people	SA	A	D	SD
6. I wish I could have more respect for myself	SA	A	D	SD
7. I feel that I'm a person of worth or at least on an equal plane with others	SA	A	D	SD
8. I feel that I have a number of good qualities	SA	A	D	SD
9. I take a positive attitude toward myself	SA	A	D	SD
10. All in all, I am inclined to feel that I am a failure	SA	A	D	SD

Between each pairs of words place an "x" for your answer. For example: If you were rating the temperature between HOT and COLD you might mark "x" as follows for "warm"

HOT:_____:_____:__x__:_____:_____:COLD

(warm)

B. DESCRIBE HOW YOU SEE YOURSELF:

Happy: _____:_____:_____:_____:_____:Sad

Sociable: _____:_____:_____:_____:_____:Unsociable

Confident: _____:_____:_____:_____:_____:Unsure

Intelligent: _____:_____:_____:_____:_____:Stupid

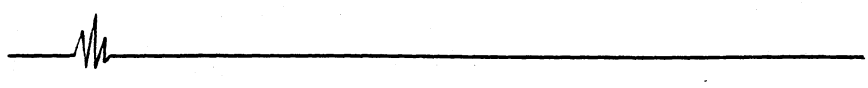
Optimistic: _____:_____:_____:_____:_____:Pessimistic

Friendly: _____:_____:_____:_____:_____:Unfriendly

Honest: _____:_____:_____:_____:_____:Dishonest

Tense: _____:_____:_____:_____:_____:Relaxed

Good: _____:_____:_____:_____:_____:Bad



Circle the answer to the right of each question which best describes to what extent you AGREE or DISAGREE with each statement.

C. WHEN WE FACE PROBLEMS OR DIFFICULTIES IN OUR FAMILY, WE RESPOND BY:

	STRONGLY AGREE	AGREE	DISAGREE	STRONGLY DISAGREE
1. Sharing our difficulties with relatives	SA	A	D	SD
2. Seeking encouragement and support from friends	SA	A	D	SD
3. Knowing that we have the power to solve major problems	SA	A	D	SD
4. Seeking information and advice from persons in other families who have faced the same or similar problems	SA	A	D	SD
5. Seeking advice from relatives (parents, etc.)	SA	A	D	SD
6. Asking neighbors for favors and assistance	SA	A	D	SD
7. Seeking assistance from community agencies and programs designed to help families in our situation	SA	A	D	SD
8. Accepting that we have the strength within our own family to solve our own problems	SA	A	D	SD
9. Accepting gifts and favors from neighbors (e.g. food, etc.)	SA	A	D	SD
10. Seeking information and advice from the family doctor	SA	A	D	SD
11. Facing problems "head-on" and trying to get solutions right away	SA	A	D	SD
12. Watching Television	SA	A	D	SD
13. Showing that we are strong	SA	A	D	SD
14. Attending church services	SA	A	D	SD
15. Accepting stressful events as a fact of life	SA	A	D	SD
16. Sharing concerns with close friends	SA	A	D	SD
17. Knowing luck plays a big part in how well we are able to solve family problems	SA	A	D	SD
18. Accepting that difficulties occur unexpectedly	SA	A	D	SD
19. Doing things with relatives (e.g. get-togethers, dinners, etc.)	SA	A	D	SD
20. Seeking professional counseling and help for family difficulties	SA	A	D	SD
21. Believing we can handle our own problems	SA	A	D	SD
22. Participating in church activities	SA	A	D	SD
23. Defining the family problem in a more positive way so that we do not get too discouraged	SA	A	D	SD
24. Asking relatives how they feel about problems we are facing	SA	A	D	SD
25. Feeling that no matter what we do to prepare, we will have difficulty handling problems	SA	A	D	SD
26. Seeking advice from a minister	SA	A	D	SD
27. Believing if we wait long enough, the problem will go away	SA	A	D	SD
28. Sharing problems with neighbors	SA	A	D	SD
29. Having faith in God	SA	A	D	SD

F-Copes by McCubbin, Larsen and Olson

The following case studies are REAL. Each of these situations occur as a regular part of these families' daily lives. Read each paragraph carefully and respond to the questions following each case study.

family A Connie J. gets up at 5 o'clock every morning to drive her husband 35 miles to his job because he is terrified of driving. The trip takes nearly 2 hours because he insists that she avoid freeways and certain congested areas.

"If I got on the freeways, I'd just have to pull over. Sometimes he'd be crying or yelling at me or hitting the dashboard in frustration. I mean it was a horrible, horrible scene!"

Below are five possible reactions to the story. Place a check by the phrase which most closely corresponds to YOUR own FEELINGS.

(check one)

_____ a. Unbelievable! I can't believe this story is real.
_____ b. I feel such sympathy for him that I want to help and console him.
_____ c. It would drive me crazy to have to take that every morning. I simply wouldn't put up with that behavior.
_____ d. This guy needs help! He's at the breaking-point.
_____ e. This behavior is childish. He needs to grow up and quit putting his poor wife through this.

family B The Mitchells have been married 20 years. About 2 years ago, Mr. Mitchell began having frequent panic attacks — breaking down and crying without knowing why. His greatest fear was getting more than 2 miles away from home.

His wife is baffled and feels helpless. "It is heart-rending to watch," she says, "and is very hard to understand. But I get so angry with him that I finally explode and tell him 'It is all in your head!'"

HOW DO YOU FEEL ABOUT MRS. MITCHELL'S ANGER? (circle a no.)

Circle a number for each statement.	AGREEMENT				DISAGREEMENT			
	Total	Strong	Moderate	Mild	Mild	Moderate	Strong	Total
1. It's a normal reaction. I'd be angry too.	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
2. She needs more patience. She's probably making things worse.	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
3. I'd probably say that and something worse, like, "You're crazy!"	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)

family C The Singletons were an active family. The children were involved in school and church functions and the father was very sociable. For the last couple of years, however, the mother feels housebound and often refuses to leave the house.

The family members are rapidly becoming impatient with mom. Why can't she go places? Three times the family has planned a vacation and had to cancel their reservations at the last minute simply because she said she couldn't manage it. One minute she says she'll go places but when it comes time to leave the house, she backs out.

WHAT DO YOU THINK THE FUTURE HOLDS FOR THIS FAMILY?

Circle a number for each statement.	AGREEMENT				DISAGREEMENT			
	Total	Strong	Moderate	Mild	Mild	Moderate	Strong	Total
1. There is no future for this family. They will probably fall apart and the marriage will end in divorce.	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
2. There will be tough times ahead but they'll make it.	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
3. Family members will resent the mother and finally lose respect for her.	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)

family D For the last four years, Mrs. Madison has been having difficulties with crowds. This has created frequent problems since the Madisons are a church-going family.

Last Sunday, after about the first 20 minutes of the church service, Mrs. Madison began to feel anxious and fearful. Finally, she became so over-whelmed that the family had to go home — right in the middle of the service.

WHAT DO YOU THINK IS GOING THROUGH THE MINDS OF THE FAMILY MEMBERS AS THEY ARE WALKING OUT OF CHURCH?

Circle a number for each statement.	AGREEMENT				DISAGREEMENT			
	Total	Strong	Moderate	Mild	Mild	Moderate	Strong	Total
1. Poor Mom! I'm embarrassed for her.	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
2. I'm disgusted with her for humiliating us like this. I wish we had another mother — a normal one!	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
3. I wonder what people are thinking about us.	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)

family E Connie J. gets up at 5 o'clock every morning to drive her husband 35 miles to his job because he is terrified of driving. The trip takes nearly 2 hours because he insists that she avoid freeways and certain congested areas..

"If I got on the freeways, I'd just have to pull over. Sometimes he'd be crying or yelling at me or hitting the dashboard in frustration. I mean it was a horrible, horrible scene!"

LISTED BELOW ARE FIVE POSSIBLE REACTIONS TO THIS CASE STUDY. INDICATE YOUR AGREEMENT OR DISAGREEMENT FOR EACH REACTION BY CIRCLING THE BEST NUMBER BETWEEN "TOTAL AGREEMENT" AND "TOTAL DISAGREEMENT."

Circle a number for each statement.	AGREEMENT				DISAGREEMENT			
	Total	Strong	Moderate	Mild	Mild	Moderate	Strong	Total
1. Unbelievable! I can't believe this story is real!	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
2. I feel such sympathy for him that I want to help and console him.	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
3. It would drive me crazy to have to take that every morning. I simply wouldn't put up with that behavior from a man.	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
4. This guy needs help! He is at the breaking point.	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
5. This behavior is childish. He needs to grow up and quit putting his wife through this.	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)

The following are TRUE-FALSE statements about family life. Read each statement carefully and circle "T" (true) or "F" (false) as it applies to your own family life.

T F 1. Family members really help and support one another.
T F 2. Family members often keep their feelings to themselves.
T F 3. We fight a lot in our family.
T F 4. We don't do things on our own very often in our family.
T F 5. We feel it is important to be the best at whatever you do.
T F 6. We often talk about political and social problems.
T F 7. We spend most weekends and evenings at home.
T F 8. Family members attend church, synagogue or Sunday School fairly often.
T F 9. Activities in our family are pretty carefully planned.
T F 10. Family members are rarely ordered around.
T F 11. We often seem to be killing time at home.
T F 12. We say anything we want to around the house.
T F 13. Family members rarely become openly angry.
T F 14. In our family, we are strongly encouraged to be independent.
T F 15. Getting ahead in life is very important in our family.
T F 16. We rarely go to lectures, plays or concerts.
T F 17. Friends often come over for dinner or to visit.
T F 18. We don't say prayers in our family.
T F 19. We are generally very neat and orderly.
T F 20. There are very few rules to follow in our family.
T F 21. We put a lot of energy into what we do at home.
T F 22. It's hard to "blow off steam" at home without upsetting somebody.
T F 23. Family members sometimes get so angry they throw things.
T F 24. We think things out for ourselves in our family.
T F 25. How much money a person makes is not very important to us.
T F 26. Learning about new and different things is very important in our family.
T F 27. Nobody in our family is active in sports, Little League, bowling, etc.
T F 28. We often talk about the religious meaning of Christmas, Passover or other holidays.
T F 29. It's often hard to find things when you need them in our household.
T F 30. There is one family member who makes most of the decisions.
T F 31. There is a feeling of togetherness in our family.
T F 32. We tell each other about our personal problems.
T F 33. Family members hardly ever lose their tempers.
T F 34. We come and go as we want to in our family.
T F 35. We believe in competition and "may the best man win."
T F 36. We are not that interested in cultural activities.
T F 37. We often go to movies, sports events, camping, etc.
T F 38. We don't believe in heaven or hell.
T F 39. Being on time is very important in our family.
T F 40. There are set ways of doing things at home.
T F 41. We rarely volunteer when something has to be done at home.
T F 42. If we feel like doing something on the spur of the moment we often just pick up and go.
T F 43. Family members often criticize each other.
T F 44. There is very little privacy in our home.
T F 45. We always strive to do things just a little better the next time.

The following are TRUE-FALSE statements about family life. Read each statement carefully and circle "T" (true) or "F" (false) as it applies to your own family life.

T F 46. We rarely have intellectual discussions.
T F 47. Everyone in our family has a hobby or two.
T F 48. Family members have strict ideas about what is right and wrong.
T F 49. People change their minds often in our family.
T F 50. There is a strong emphasis on following rules in our family.
T F 51. Family members rarely back each other up.
T F 52. Someone usually gets upset if you complain in our family.
T F 53. Family members sometimes hit each other.
T F 54. Family members almost always rely on themselves when a problem comes up.
T F 55. Family members rarely worry about job promotions, school grades, etc.
T F 56. Someone in our family plays a musical instrument.
T F 57. Family members are not very involved in recreational activities outside work or school.
T F 58. We believe there are some things you just have to take on faith.
T F 59. Family members make sure their rooms are neat.
T F 60. Everyone has an equal say in family decisions.
T F 61. There is very little group spirit in our family.
T F 62. Money and paying bills is openly talked about in our family.
T F 63. If there's a disagreement in our family, we try hard to smooth things over and keep peace.
T F 64. Family members strongly encourage each other to stand up for their rights.
T F 65. In our family, we don't try that hard to succeed.
T F 66. Family members often go to the library.
T F 67. Family members sometimes attend courses or take lessons for some hobby or interest (outside of school).
T F 68. In our family, each person has different ideas about what is right and wrong.
T F 69. Each person's duties are clearly defined in our family.
T F 70. We can do whatever we want to in our family.
T F 71. We really get along well with each other.
T F 72. We are usually careful about what we say to each other.
T F 73. Family members often try to one-up or out-do each other.
T F 74. It's hard to be by yourself without hurting someone's feelings in our household.
T F 75. "Work before play" is the rule in our family.
T F 76. Watching T.V. is more important than reading in our family.
T F 77. Family members go out a lot.
T F 78. The Bible is a very important book in our home.
T F 79. Money is not handled very carefully in our family.
T F 80. Rules are pretty inflexible in our household.
T F 81. There is plenty of time and attention for everyone in our family.
T F 82. There are a lot of spontaneous discussions in our family.
T F 83. In our family, we believe you don't ever get anywhere by raising your voice.
T F 84. We are not really encouraged to speak up for ourselves in our family.
T F 85. Family members are often compared with others as to how well they are doing at school or work.
T F 86. Family members really like music, art and literature.
T F 87. Our main form of entertainment is watching T.V. or listening to the radio.
T F 88. Family members believe that if you sin you will be punished.
T F 89. Dishes are usually done immediately after eating.
T F 90. You can't get away with much in our family.

You and your family

34 Your age (-)_____ 36 Are you (-1)_____ Male (2)_____ Female

38 Average annual family income

(-1)_____Less than $10,000
(2)_____$10,000 to $20,000
(3)_____$20,000 to $30,000
(4)_____$30,000 to $40,000
(5)_____$40,000 to $50,000
(6)_____$50,000 and over

40 What is the last year in school you completed?

(-1)_____Grade school
(2)_____Some high school
(3)_____Graduated high school
(4)_____Some college
(5)_____Graduated college
(6)_____Postgraduate work

42 What is your marital status?

(-1)_____Never married
(2)_____Married
(3)_____Remarried
(4)_____Divorced
(5)_____Separated
(6)_____Widowed

44 Do you have any children who are:

(-1)_____Preschool age or grade school
(2)_____In junior high or high school
(3)_____Attending college
(4)_____No children living at home
(5)_____No children

46 Is the woman of the house employed outside the home?

(-1)_____Full-time
(2)_____Part-time
(3)_____Not at all
(4)_____No wife

48 What is your occupation, business or profession ( )

_____

50 What is your specific job role or title? ( )

_____

52 Do you have agoraphobia? (1) Yes_____ (2) No_____

53 IF YES, WHAT WAS THE DATE OF YOUR FIRST PANIC ATTACK_____ (year)

(54) How would you rate the present state of your phobic symptoms on the scale below?

0	1	2	3	4	5	6	7	8
No phobias present		Slightly disturbing/ not really disabling		Definitely disturbing/ disabling		Markedly disturbing/ disabling	Very severely disturbing/ disabling	

0 1 2 3 4 5 6 7 8

Please circle one number between 0 and 8.

Prepared by Dan H. McCaghren, M.S. under the supervision of Godfrey J. Ellis, Ph.D., Associate Professor, Dept. Family Relations and Child Development, Oklahoma State University.

APPENDIX B

COVER LETTER FOR CONTROL SAMPLE

Oklahoma State University

DEPARTMENT OF FAMILY RELATIONS
AND CHILD DEVELOPMENT

STILLWATER, OKLAHOMA 74078
241 HOME ECONOMICS WEST
(405) 624-5057

April 9, 1984

Dear Parent,

Some people cannot fly in a plane, ride on an escalator, or drive on the freeway. Perhaps you've known someone who is afraid to leave the house to go shopping, to a movie, or even to a restaurant. They may be totally housebound.

We are currently conducting a project designed to help families suffering from this malady -- known as, AGORAPHOBIA. We would appreciate your help.

Enclosed are two copies of a brochure -- one for your spouse and one for yourself. Would you be so kind as to read the brief questions and jot down your responses?

1. It is important that you answer the questions as honestly as possible.

2. There are no right or wrong answers -- your first impression is usually the best answer.

3. Please do not compare answers with your spouse until after you have returned them to your child's lab teacher in the manilla envelope.

4. YOUR ANSWERS WILL BE ANONYMOUS -- There will be no record kept of any individual names or responses; we're only interested in GROUP answers.

Could we ask you to fill out your brochure this weekend? We will begin collecting them next Monday (April 11th).

Families with agoraphobia need treatment and therapy. At this point, much remains to be learned about this illness. Your cooperation will aid in further understanding these families.

THANK YOU for your contribution to this project.

Sincerely,

Leone List, Director
Child Development Labs

Godfrey J. Ellis
Assoc Prof, FRCD

Dan H. McCaghren
Project Director

APPENDIX C

COVER LETTER FOR AGORAPHOBIC SAMPLE

C. ROBERT INGRAM, JR., Ph.D.
Clinical Psychology

Suite 119
12860 Hillcrest Road
Dallas, Texas 75230
(214) 386-6327

19 April 1984

Dear Friend,

Although it has been some time since you have completed group, I am writing this to ask a favor. As you may remember me mentioning in group, Dan McCaghren, Director of Southern Hills Family Services, has been conducting his doctoral studies in the area of agoraphobia. As you know, precious little is known about this problem which afflicts so many people today.

Dan's research is attempting to discover how family relationships tie into agoraphobia. I have been one of his consulting supervisors throughout the planning of his study and I firmly believe that the study will bring new understanding to this difficult problem.

What I ask is that you and your spouse each take approximately twenty minutes to complete one of the enclosed forms. You do not need to identify yourself on the forms and the results, therefore are known to you alone. It is important that you return the questionaires within a week (in the envelopes provided) and that you do not spend a great deal of time on any one answer.

Since the results are confidential, neither Dan nor myself will be able to thank you after you return them; however, please allow me this opportunity to thank you at this time. In addition, I sincerely hope that your life is going well for you.

Sincerely,

C. Robert Ingram, Jr., Ph.D.
Clinical Psychologist

APPENDIX D

QUESTIONNAIRE -- PILOT STUDY I

Thanks for participating in this PILOT STUDY.

Please, read the following CASE STUDIES carefully and respond to the questions following each case study.

Also, as you work your way through this test, feel free to offer any suggestions for improvement by writing in the margins:

1. Is the question clear?
2. Did you have any confusion about the question?
3. Could the question have been stated better?

Thanks again for your help in this preliminary run.

Dan H. McCaghren
Dept. Family Relations
Oklahoma State University

The following case studies are REAL. Each of these situations occur as a regular part of these families daily life.

Would you please take the time to read each paragraph carefully and respond to the question following each case study.

FAMILY A

Connie J. gets up at 5 a.m. to drive her husband 35 miles to his job because he has become terrified of driving. The trip takes nearly 2 hours because he insists that she avoid freeways and certain congested areas. "If I got on the freeway, I'd just have to pull over. Sometimes he'd be crying or yelling at me or hitting the dashboard in frustration. I mean it was a horrible, horrible scene!"

What is your initial reaction to the behavior of Connie's husband?

1. _____
2. _____
3. _____
4. _____

FAMILY B

The Harwell family arranges its activities around the mother, Jo. She suffers from fear of just about everything: wide-open spaces, closed-in spaces, crowds and elevators. Driving is her number one fear. At times, Jo can scarcely stir ourside the house. Her husband does most of the shopping and the children run the errands because Jo is house-bound.

Were you advising this family on how to deal with the mother, Jo, what might you suggest?

1. _____
2. _____
3. _____
4. _____

FAMLY C

Troy B. is 29 years of age and is embarrassed because whenever he goes out in public, he has to have an 'escape route'. Troy has to sit near the door in a restraunt or in the aisle seat in the theater. If he goes to a party, he tells the host he isn't feeling well in case an anxiety attack comes over him and forces him to leave the party.

What do you think Troy feel about himself?

1. _____
2. _____
3. _____

FAMILY D

Dave T's wife is beset by an unreasonably intense fear in many situations like supermarkets and other stores, elevators, escalators, theaters, restraunts, parties and meetings. She may go into one of her "attacks" at any time in which her palms sweat, her stomach churns and her throat tightens. She fhas difficulty swallowing and at times feels as though she can't breathe and has accompanying chest pains.

What do you think is the matter with Dave's wife?

1. _____
2. _____ _____
3. _____
4. _____

FAMILY E

The Mitchells were married 20 years ago. About 2 years ago, Mr. Mitchell began having frequent panic attacks -- breaking down and crying without knowing why. His greatest fear was getting more than 2 miles away from home. His wife is baffled and feels helpless. "It is heart-rending to watch" she says "and is very hard to understand. But I get so angry with him that I finally explode and tell him 'It is all in your head'."

How do you feel about Mrs. Mitchell's reaction to her husband's emotional outbursts?

1. _____
2. _____
3. _____

FAMILY F

The Singletons are an active family. The children are active in school and church functions and the father is very sociable. For the last couple of years, however, the mother has difficulty leaving the house. The children are beginning to wonder why Mom doesn't doesn't take them places. Three times the family has planned a vacation and cancelled their reservations at the last minute simply because she said she couldn't manage it. One minute she says she'll go and the next minute she says she can't.

What do you think the future holds for this family?

1. _____
2. _____
3. _____
4. _____

FAMILY G

The Madison's have been a very church-going family. Last Sunday after about the first 20 minutes of the service, Mrs. Madison began trembling. Finally, she became so uncomfortable the family had to leave -- right in the middle of the service. This has happened repeatedly for the last four years.

What do you think is going through the minds of the Madisons as they walk out in the very middle of church?

1. _____
2. _____
3. _____
4. _____

APPENDIX E

QUESTIONNAIRE -- PILOT STUDY II

The following case studies are REAL. Each of these situations occur as a regular part of these families daily lives.

Read each paragraph carefully and respond to the questions following each case study.

FAMILY A

Connie J. gets up at 5 O'Clock every morning to drive her husband 35 miles to his job because he is terrified of driving. The trip takes nearly 2 hours because he insists that she avoid freeways and certain congested areas.

"If I got on the freeways, I'd just have to pull over. Sometimes he'd be crying or yelling at me or hitting the dashboard in frustration. I mean it was a horrible, horrible scene!"

Below are five possible reactions to the story. Place a check by the phrase which which most closely corresponds to YOUR OWN feelings.

(check one)

___ a. Unbelievable! I can't believe this story is real.
___ b. I feel such sympathy for him that I want to help and console him.
___ c. It would drive me crazy to have to take that every morning. I simply wouldn't put up with that behavior.
___ d. This guy needs help! He's at the breaking-point.
___ e. This behavior is childish. He needs to grow up and quit putting his poor wife through this.

FAMILY B

The Mitchells have been married 20 years. About 2 years ago, Mr. Mitchell began having frequent panic attacks -- breaking down and crying without knowing why. His greatest fear was getting more than 2 miles away from home.

His wife is baffled and feels helpless. "It is heart-rending to watch" she says, "and is very hard to understand. But I get so angry wih him that I finally explode and tell him 'It is all in your head'!"

How do YOU FEEL about Mrs. Mitchell's anger? (circle a number)

---

a. IT'S A NORMAL REACTION. I'D BE ANGRY TOO.

1	2	3	4	5	6	7	8	9	10
Total Disagreement				Neutral					Total Agreement

b. SHE NEEDS MORE PATIENCE. SHE'S PROBABLY MAKING THINGS WORSE.

1	2	3	4	5	6	7	8	9	10
Total Disagreement				Neutral					Total Agreement

c. I'D PROBABLY SAY THAT AND SOMETHING WORSE LIKE, "YOU'RE CRAZY!"

1	2	3	4	5	6	7	8	9	10
Total Disagreement				Neutral					Total Agreement

FAMILY C

The Singletons are an active family. The children are active in school and church functions and the father is very sociable. For the last couple of years, however, the mother has difficulty leaving the house.

The children are beginning to wonder why Mom doesn't take them places. Three times the family has planned a vacation and cancelled their reservations at the last minute simply because she said she couldn't manage it. One minute she says she'll go and the next minute she says she can't.

What do you think the FUTURE holds for this family? (circle a number)

---

a. THERE IS NO FUTURE FOR THIS FAMILY. THEY WILL PROBABLY FALL APART AND THE MARRIAGE WILL END IN DIVORCE.

1 2 3 4 5 6 7 8 9 10

Total Disagreement — Neutral — Total Agreement

b. THERE WILL BE TOUGH TIMES AHEAD BUT THEY'LL MAKE IT.

1 2 3 4 5 6 7 8 9 10

Total Disagreement — Neutral — Total Agreement

c. FAMILY MEMBERS WILL RESENT THE MOTHER AND FINALLY LOSE RESPECT FOR HER.

1 2 3 4 5 6 7 8 9 10

Total Disagreement — Neutral — Total Agreement

FAMILY D

The Madisons have been a very church-going family. Last Sunday after about the first 20 minutes of the service, Mrs. Madison began trembling. Finally, she became so uncomfortable the family had to leave -- right in the middle of the service.

This has happened repeatedly for the last four years.

What do you think is GOING THROUGH THE MINDS of the FAMILY members as they are walking out? (circle one number)

---

a. POOR MOM! I'M EMBARRASSED FOR HER...

1	2	3	4	5	6	7	8	9	10
Total Disagreement				Neutral					Total Agreement

b. I'M DISGUSTED WITH HER FOR HUMILIATING US LIKE THIS. I WISH WE HAD ANOTHER MOTHER. . . A NORMAL ONE!

1	2	3	4	5	6	7	8	9	10
Total Disagreement				Neutral					Total Agreement

FAMILY E

Connie J. gets up at 5 O'Clock every morning to drive her husband 35 miles to his job because he is terrified of driving. The trip takes nearly 2 hours because he insists that she avoid freeways and certain congested areas.

"If I got on the freeways," Connie said, "I'd just have to pull over. Sometimes he'd be crying or yelling at me or hitting the dashboard in frustration. I mean it was a horrible, horrible scene!"

Listed below are five possible REACTIONS. Indicate your agreement or disagreement by circling the best number between "total agreement" and "total disagreement".

---

a. UNBELIEVEABLE! I CAN'T BELIEVE THIS STORY IS REAL.

1 2 3 4 5 6 7 8 9 10

Total Disagreement — Neutral — Total Agreement

b. I FEEL SUCH SYMPATHY FOR HIM THAT I WANT TO HELP AND CONSOLE HIM.

1 2 3 4 5 6 7 8 9 10

Total Disagreement — Neutral — Total Agreement

c. IT WOULD DRIVE ME CRAZY TO HAVE TO TAKE THAT EVERY MORNING. I SIMPLY WOULDN'T PUT UP WITH THAT BEHAVIOR.

1 2 3 4 5 6 7 8 9 10

Total Disagreement — Neutral — Total Agreement

d. THIS GUY NEEDS HELP! HE IS AT THE BREAKING-POINT.

1 2 3 4 5 6 7 8 9 10

Total Disagreement — Neutral — Total Agreement

e. THIS BEHAVIOR IS CHILDISH. HE NEEDS TO GROW UP AND QUIT PUTTING HIS WIFE THROUGH THIS.

1 2 3 4 5 6 7 8 9 10

Total Disagareement — Neutral — Total Agreement

APPENDIX F

INTERVIEW VERBATIM: FAMILY A

Subject: Agoraphobic Wife -- Age 28

INTERVIEWER: Do you have any recollection of your very first encounter with the agoraphobia?

SUBJECT: Oh, yes! It was June 8, 1981. That date is very clear and even burned into my memory forever.

INTERVIEWER: Exactly what was going on in your life at that time?

SUBJECT: I had just given birth to my second child at the hospital's Alternate Birthing Center. Within twenty-four hours I was back home taking care of our two year old plus the new baby. I had no one around to help me. I realize now that that was a mistake. I was pushing too hard.

INTERVIEWER: Have you any idea what brought the episode on?

SUBJECT: Well, my own theory is the trauma and stress of having a baby very quickly had a great deal to do with it. You see, within thirty minutes of his birth I was out of bed, showered and into the next room receiving the first visitor. That evening they brought me the baby and left him for the entire night so I didn't get any sleep that night. This was the second night without sleep.

INTERVIEWER: So things were beginning to pile up . . . ?

SUBJECT: Yes. I went home the next morning. Of course the first night a newborn is home, no one gets any sleep. I didn't have any help, so for the third night in a row I had no sleep. Then, too, the two year old was pulling all sorts of tricks -- climbing over furniture and jumping off the table. She was doing all sorts of wild and crazy things. I realize of course her behavior was due to the new baby.

INTERVIEWER: What about the actual onset of the panic attack?

SUBJECT: Well, the very next morning (second morning home) I was drinking a cup of coffee to keep on functioning. All of a sudden it was as though I had a shot of Novacaine in my left arm. It wasn't even tingling . . . it seemed dead. I thought that was rather odd. Then the sensation began moving up into my shoulders and onto my face. Then it began moving down into my leg. Even my tongue . . . it got so thick I thought I was going to choke and suffocate. At this point I got panicky and called my husband and told him call the emergency room because something was going wrong with me.

INTERVIEWER: What was the hospital's diagnosis of what was going on with you?

SUBJECT: They told him "She's hyperventilating. Give her a paper bag and call us back if it doesn't work." So my husband got this huge paper bag and put it all the way over my head and made me breathe into it. It did not work too well. I told him to call the hospital back.

INTERVIEWER: This must have been pretty frightening. What did you think was happening to you?

SUBJECT: I thought I was having a stroke. The ambulance took me to the emergency room and began running blood tests to determine what was wrong. They called my doctor, an obstetrician, and he would not even come down to the emergency room to see me. He told the nurses "Oh, she just nervous." At that point I insisted, "I want my doctor!" I even begged them to re-admit me to the hospital. They told me "We can't do that. You have this two-day old baby and having already been home, he would bring germs into the nursery. We will have to send you back home. There is nothing wrong with you. You are just hyperventilating." I told them to give me my paper sack back because I was still having difficulty breathing. On the way home, the breathing difficulty continued.

INTERVIEWER: Not having gotten any satisfaction from the medical community and back home with your paper sack, how did you try to handle the malady and what did you tell your friends?

SUBJECTS: My husband did not know what to tell the people and I did not know what to say to them either. He ended up telling them that I was just hyperventilating because I was so exhausted.

INTERVIEWER: Did the agoraphobia have any effect on your relationships with people?

SUBJECT: Yes. I spent most of my time lying in bed with the paper sack. When the doorbell rang, that was it! I began gulping air and could not bring myself to go out to greet my visitors.

INTERVIEWER: Were there any accompanying symptoms besides the difficulty in breathing?

SUBJECT: Yes. The the chest pain convinced me I was having a heart attack. I believed this for a year. Also, there was a numbness primarily on the left side. Dry mouth and sweaty palms. When I left my room and tried to talk to people It was like I was drunk. In fact, I kept telling my husband that I was drunk all the time or had been shot full of drugs, although I hadn't taken any medication. I just didn't know what was wrong. A week after I returned home from the hospital, I did go to church accompanied by my mother. During services, my mother just sat there and looked at me the whole time because I was all "zombied" out.

INTERVIEWER: Obviously you were not getting any better with time. Where did you go from there?

SUBJECT: I finally called the doctor again. I remember sitting in the bed rocking back and forth, crying and begging him to do something.

INTERVIEWER: Did the doctor offer any diagnosis?

SUBJECT: Yes. He replied, "Your adrenal glands have gone haywire. What we're going to do is send out some sleeping pills." He sent out sleeping pills, some Valium and I slept for the next three days. Over the phone he kept telling me I was upset over the birth of the baby and needed to relax. I kept insisting this was not the case and something was happening to me.

INTERVIEWER: How did you manage to function during this time?

SUBJECT: I would get out and go to church but I couldn't function with people at all. This was really sad because about this time my husband was elected an officer at our church -- Deacon of Fellowship. And what does the wife of this particular officer do but plan, manage dinners and other church functions. I even had to emcee the annual Women's Retreat. Finally, however, I had to go to my mothers house (50 miles away) because I simply could not function. She took care of me for about month. While there I couldn't sleep and I had already taken all the Valium which didn't seem to do any good other than slow my heart rate down. I never really knew how to describe to anyone what was going on inside me other than "I just can't see right . . . ."

INTERVIEWER: . . . You mean like "telescoping" . . . .

SUBJECT: Yes! If only I had known that word, "telescoping."

INTERVIEWER: So you went to spend several weeks with your mother because you were having difficulty functioning?

SUBJECT: Yes. I tried to return to my own home once but I ended up having to go back to mother's. While there I remember a particularly difficult evening in which I could not sleep all night so we finally called my doctor long distance. I wasn't the one who placed the phone call because I was so upset, crying and couldn't figure out what I was even talking about. My husband called the doctor and told him, "My wife is having a really rough time. She can't sleep and things look strange to her." The doctor responded "Well, it's her hormones and she will just have to wean the baby first of all." This business of weaning the baby created for all sorts of guilt since I had been so outspoken to all my friends about the importance of nursing your infant. Weaning the baby just added even more anxiety.

INTERVIEWER: So you were not able to live up to your well-known convictions regarding nursing your own child?

SUBJECT: That's right. Every time I put a bottle into his mouth, I would die inside. After all, I had really talked up this business of nursing your child. But I did learn you can raise a baby by the bottle (laughter). The child really can survive but it was hard on me at this particular time with all the other anxiety.

INTERVIEWER: Besides telling you to wean the baby, what else did your physician tell you?

SUBJECT: He said to wean the baby and if I didn't improve in two weeks to call him again. This was the third time the doctor had turned me down to see me. At this point I told my mother to call her own physician because I had to see someone. Even when I was just sitting on the couch, the room was spinning around. My mom called him and he called out a prescription of Transene in the night. It was so bad at this point that once my dad reached out to touch me and console me with "It's going to be all right . . . you will be okay" that I just threw him back to that he fell out of his chair. I didn't want anyone to come near me or to touch me. Because of my bizarre behavior I became terrified of the medication, thinking that it was the drugs causing my problems.

INTERVIEWER: So you them became averse to taking the medication?

SUBJECT: Yes, I thought, "this stuff is causing me to act strange." On one occasion when my parents were insisting I take my medication I begged, "please don't make me take it" but they kept on insisting and practically forced it down my throat and I became like a wild person. Finally, I was just sitting on the couch rocking back and forth. All the while I felt I was "losing it" and kept on telling myself to hang on. I kept telling my family I was sick and just hanging on to any single thread of reality. Next morning I went to the doctor and he said "maybe it's Thyroid, maybe its hormones, maybe its this, maybe its that . . . ." All the tests he ran came back normal, however.

INTERVIEWER: Since the battery of lab tests did not come up with anything, where did the physician go from there?

SUBJECT: The doctor said I was suffering from post-natal depression with anxiety. Next he prescribed an anti-depressant (Elavil), a big bunch of sleeping pills and several other drugs.

INTERVIEWER: With all this medication, did you find yourself sleeping a great deal of the time?

SUBJECT: Yes. For entire days at a time I was sleeping again. During this time, I did not see the baby for a week; everybody else took care of him. I don't really know how long this went on but none of the drugs the doctors gave me seemed to do any good. After taking the anti-depressant for 6 months, I took myself off because the side-effects were the same as I had before taking the drug - dryness of mouth, dizziness, difficulty in breathing and difficulty in seeing.

INTERVIEWER: So at this point you were taking things into your own hands?

SUBJECT: Yes. I even went to a Chiropractor. After the X-Rays, he said, "Gee, you've had your baby and the pelvic bones did not come back together. They are at an angle and your entire spine is twisted causing pressure on your nerves which effect your sight and making it difficult

for you to see. The Chiropractor showed me the X-rays, and sure enough, I could see the curvature of the spine. and said to myself, "Yeah, this makes sense." So I was under Chiropractic care for a year. When I would leave the Chiropractor's office following an adjustment, I would drive myself home although I could barely see. I tried this for a year and each time told myself, "This is going to get better." Finally, he ran some tests and concluded I was hypoglycemic and proceeded to put me on a special diet. Still I remained just as nervous and continued to have the anxiety attacks. Later, Glucose tests were run and I was told I was a borderline diabetic.

I wasn't completely satisfied with this diagnosis of diabetes, so I took to the telephone book in search of a specialist in diabetes and one who was a woman. The diagnosis of diabetes frightened me so that I could not even eat a banana without having a panic attack for fear of the sugar it contained. I couldn't eat anything I thought might have sugar in it. I got down to eating plain meat and plain vegetables . . . period! No grains. Nothing. I was scared of anything that hinted of the panic attacks.

INTERVIEWER: Having shared all this with your new diabetes specialist, what did she say?

SUBJECT: She told me I was not diabetic but was very susceptible to suggestion and that she would run another Glucose Test to prove to me that I did not have a problem with diabetes. She was right. The glucose test came back normal. She did say, however, that she heard a "click" in the heart valve and was going to send me to the hospital to have tests run on the heart. The tests seemed to indicate a Mitral Valve Prolapse. I then read everything I could find on this subject and found out it could contribute to the anxiety.

INTERVIEWER: Did this then solve your problems?

SUBJECT: I was satisfied with the "Mitral Valve Prolapse" answer for quite a while until I went to a hospital to visit a friend who just had a baby. While visiting her the anxiety started coming back and I said to myself, "Now wait a minute! My brain told me something that brought the anxiety on and my problem is NOT my heart. Why didn't the anxiety happen in the parking lot and why did it happen in the hospital room?"

INTERVIEWER: By this time you are probably getting pretty confused?

SUBJECT: In trying to figure out what is going on I continued to read. With this problem you read everything you can possibly get your hands on. I had heard and read a little about Agoraphobia but I wasn't for sure it applied to me because I wasn't "house-bound" and didn't have difficulty crossing streets, bridges, etc. My particular problem seems to be that I will survive a stressful situation and weather it fine only to be a wreck for the following two days.

INTERVIEWER: If all this began in June, 1981, how would you describe the last couple of years?

SUBJECT: I don't even remember the first ten months of my baby's life. They are gone. I have no memory of him as a baby because I was just going through the motions of living. I felt like I was drugged 24 hours a day. It would never go away and at times it would really be acute. Finally, after about a year of this I said to myself "You better get a handle on yourself. There is no one out there to help you and you are going to have this thing for the rest of your life. You might as well accept it and learn to live with it." Everyone kept telling me "It's just your nerves. You are unduly nervous." This is NOT true! Ask my father and he will verify that I am not the nervous type person. The first year and a half were impossible. The last year has been a little better. I now have long periods where I am normal and don't have any strange feelings in my head. I can go days and even sleep 8 hours a night. And this is wonderful because there was a time when I couldn't sleep at all. Still about once a week there will be a night where I can't sleep and will go into the den and just read to keep from waking the family. The last year hasn't been too bad and I can pretty well handle things the way they are. I do worry sometimes about what might happen 2 or 3 days later . . . .

INTERVIEWER: . . . You mean 2 or 3 days after doing something particularly stressful?

SUBJECT: That's right. I often question whether or not I want to participate in certain stressful events for fear that I will "pay for it" a few days later. Music is my forte and I have been a performer for most of my life. My family and the parents of my students are always after me to do a recital but I keep putting them off . . . wondering . . . . I do seem to be doing better, especially since the first year was hell on earth. I simply did not have control of my life.

INTERVIEWER: Do you remember what was running through you head at the time you were not in control?

SUBJECT: I was just sure I had a brain tumor or was going crazy. I knew I was going to die from a brain tumor because no one would give me a CAT Scan. I was ready to go anywhere or do anything to find out what was wrong. But no one would seem to help me, so I reconciled myself "If I die (from a tumor) I just die."

INTERVIEWER: Do you remember your first encounter with the word, "agoraphobia"?

SUBJECT: I'm sure it was an article in a magazine I had picked up.

INTERVIEWER: Some people have difficulties like yours and try to hide it.

SUBJECT: . . . Only SOME people (laughter) . . . .

INTERVIEWER: Who knows about your agoraphobia? Your husband?

SUBJECT: Oh, yeah.

INTERVIEWER: What about your in-laws? Are they in on what's happening with you?

SUBJECT: They went through the problems with me for the first 6 months but they don't know I still experience it.

INTERVIEWER: How much do your own parents know?

SUBJECT: My parents took care of me the first few months through this. My mother had experienced a lot of the same things but she would not even admit to me that she had. My mother knew TOO much about what I was feeling, experiencing and going through at that time . . . .

INTERVIEWER: . . . and you don't think she learned all that from a book?

SUBJECT: Right! She knew too much! Even now she will not admit to it or talk about it. There are some people who knew I was having some problems when the baby was born but have assumed I got better. I talk to these people and say "We finally found out it was a heart murmur." End of story. A lot of our friends don't even know it. At the beginning when things were pretty rough some of our really good friends came to the rescue and were real good to me. They would take the baby and say "(subject's name) needs a break so we will take care of the kids." They were so good to me at the time; Their heart was good but then a few minutes later they would joke with me saying, "(subject's name), are you going to be all right now?" Everyone would laugh and I would laugh right along with them. They just thought it (my problem) was all in he past. They still kid me about it.

INTERVIEWER: What would you say are the situations you dread the most?

SUBJECT: New situations. It is not so much a feeling of dread as much as it is wondering if I am going to be okay through it. All my life I have been able to handle really about any sort of situation or perform for any amount of people individually or with a symphony. It is not so much that I am scared of talking to people, groups, etc. but simply wondering will I be okay . . . will my heart start going crazy again?

INTERVIEWER: It sounds as though for about 26 years you proceeded through life pretty much in control, with no doubts about you or your abilities and then suddenly in June of 1981 the roof caved in and you are not sure anymore.

SUBJECT: That's true.

INTERVIEWER: How do you handle performance situations now?

SUBJECT: I've avoided them for the most part. Like I said before, my family and the parents of my piano students have been after me for quite some time to do a piano recital. And I will say, "I will. I am planning on doing it." And I will even start to work on a few pieces of music but I never get down to doing the recital . . . I'm not for sure if I can do it. That's sad because I REALLY want to but I'm afraid.

INTERVIEWER: How does your husband handle all this?

SUBJECT: Poor (husband's name)! He is really in tune with people; more than most. He has really tried. Yet there are times when I want to kick him because he doesn't understand. As hard as he tries he still has difficulty with it. He would not talk to our friends about what was really going on with me. When I could not get out, he would cover by saying "She's not feeling well today." We lost some friends over this because they wanted to help us but (husband's name) would cover so well they felt he was brushing them off.

INTERVIEWER: What was the best thing (husband's name) did for you during this time?

SUBJECT: The best thing he did was to take over the responsibility of getting up at night with the kids. Out two-year old does not sleep through the night. I don't mean he gets up once a night but two or three times every night. I could get up with him, but once I do I do not go back to sleep. My husband realized this and got up. It did not matter if he had only gotten a few hours of sleep, he was always the one to get up with the kids. I really appreciate this.

INTERVIEWER: So there has been an alteration in your husband's parenting role?

SUBJECT: Yes, considering he has to get up at six in the morning and I could sleep 'til ten if I chose to. With all this he tries to understand but he simply doesn't. He admits he cannot understand the problem and I try to explain "Try to imagine 24 hours being slightly tipsy and trying not to let anybody know."

INTERVIEWER: Do you and your husband talk much about it?

SUBJECT: There was a period where I couldn't talk about it. All I could say was "Look, I'm having trouble today." That's all I could say.

INTERVIEWER: And he understood what this meant?

SUBJECT: That's right.

INTERVIEWER: What were you trying to tell him when you said, "Look, I'm having trouble today"? And, what message did he get from this?

SUBJECT: I think he understood it as "Leave her alone right now. Don't stress her out. Be careful." He got to where he would pay all the bills. He wouldn't even let me open them for fear they might cause stress.

INTERVIEWER: . . . trying to protect you?

SUBJECT: Yes, trying to protect me.

Sometimes I don't answer the telephone because I can't deal with people and he knows this. If he calls home and I don't answer, he signals by letting it ring twice and then hangs up and calls again. It is good that he tries to understand but most of the time we don't talk about it. If he tried to ask about it, it would be too much for me. So we don't talk about it. All I have to say is "Will you take the kids?" or "I'm not feeling well" and he gets the point.

INTERVIEWER: So (husband's name) has picked up an extra amount of the parenting load?

SUBJECT: Yes.

INTERVIEWER: Sounds as though you have been through the mill trying to merely find out what was wrong?

SUBJECT: Well, my mother's physician identified it as post-natal depression and anxiety, and said if the medication did not help, he was going to put me in the hospital for psychiatric observation. This was when I began to act!

INTERVIEWER: . . . This was when you began to act . . . ?

SUBJECT: Yes. This was when I began to cover it up. Everyone would remark, "Boy, the Elavil (anti-depressant) is really helping you," and I would pretend with "Yes. It really is. I'm doing a lot better."

INTERVIEWER: Still covering up?

SUBJECT: Yeah . . . . What I really resent is the condescending tone of voice of my doctor as he gives me his little pats on the back and moralisms. I know he is trying to help out but he still has it written all over his face -- "You little neurotic lady."

INTERVIEWER: (subject's name), did you ever get angry with the medical community?

SUBJECT: Yes. This is when I went to the Chiropractor.

INTERVIEWER: So you have tried just about every avenue seeking help?

SUBJECT: Yes . . . except I never went to a Psychiatrist or Psychologist. I just did not want to believe it was something in my head.

INTERVIEWER: (subject's name), did anger ever play a role in any of this?

SUBJECT: It's interesting you ask that. My father just commented the other day that he could not remember my ever getting angry or upset as a child--I was the peacemaker in our family. About 5 months ago, however, I got so mad . . . I have NEVER, NEVER, NEVER exploded like that! But I started screaming at the top of my lungs -- the kids had been really acting up that day -- and I sat there screaming and beating the floor

with my fists until they were sore. Then I felt guilty and cried ad cried . . . wondering "What's wrong with me!" I had just lost control! I've probably had more flare-ups of anger in the last 6 months than ever before. I'm frustrated because of the futility of not knowing what's wrong with me and getting a multiplicity of diagnoses from doctors.

INTERVIEWER: In your search for an answer . . . I wonder just how much this has cost you in dollars and cents?

SUBJECT: Whoa! I don't even want to think about that. I know it has cost us a bunch! This is one of the reasons I have stopped trying to even find out what's wrong with me . . . we've just spent so much on this.

INTERVIEWER: If you could send any message to people who live with agoraphobics, what might that message be?

SUBJECT: First of all, tell them not to be condescending. Don't pat us on the back and say, "It's going to be okay." Then, too, talk about it if your spouse wants to but otherwise just BE THERE! Sometimes I want to be touched and at other times I can't stand to have my husband around me. Tell them to please be sensitive to this and NOT TAKE IT PERSONAL! It is not rejection. When you are having a panic attack and your heart is pounding and your vision is distorted, your entire thought processes are centered around the panic attack and it is not a matter of being selfish. When having a panic attack, all I can deal with is myself. I'm not trying to be selfish, but the panic attack is all absorbing and at this point I cannot give my attention to anything other than surviving. I have told my husband that "Sometimes it is all I can do to sit still and stay here . I'm just trying to keep my head above water and I can't deal with anybody else at this point."

Just remind them that when your (agoraphobic) spouse cannot give you the attention you want and please don't take that personal, because it is not rejection. At times I have tried to force myself to do things for my husband when I was having a difficult time. After all he needs attention too. I have tried to go to a movie with him during a difficult time, but the wide screen, the loud sounds and moving colors was more than I could take. My husband always wants to sit in the front of the theater, close to the screen while I prefer sitting further back. I have had to literally grit my teeth to keep from leaving the theater.

INTERVIEWER: How would you say this has affected your relationship with your husband?

SUBJECT: I feel, as a result of the agoraphobia, I am a more independent person. All my life I have been a highly dependent person. It was a standing joke -- point (subject's name) in the right direction, so she will get there. I played the role of the scatterbrained type. When I went to college, I had to latch onto a man in a hurry so I could have someone to lean on. However, I am finding myself becoming more independent as a result of the illness. When it gets really bad, I am driven into a corner and say to myself, "Hey! It is up to you. You are the only one doing anything for yourself." This may sound terrible,

but when it gets bad, my husband cannot help me, nobody can help me, and its up to me to get through it. I say all that to say that between (husband's name) and me there is probably a distance that did not exist before the illness. I don't need him like I needed him before. Yes, he would try to protect me from stress, but when stress and anxiety came down, it was JUST ME! Yes . . . there is definitely a distance that wasn't there before.

INTERVIEWER: It sounds like overall, your husband has been rather sympathetic?

SUBJECT: Sometimes I would not agree with that, but when I look back, I'm sure you're right. When I sit down and make myself think about it, he really is a pretty good guy. He has worked hard at this. But when I'm living it sometimes, and right in the midst of the illness, he doesn't have any idea what going on inside me.

INTERVIEWER: If I ask you to list the ten most significant events in your life, would you list the agoraphobia among them?

SUBJECT: Right now I would list the illness as the Number 1 significant event of my life because of what it has done to me and my ability to function. I can look back and list the birth of my children, my marriage as some of my most significant times, BUT they haven't totally CHANGED ME!

INTERVIEWER: What has it done then?

SUBJECT: In one respect, I am stronger and more independent because of it. Yet in another way, I guess I am more cynical. I am not the sweet, naive little girl I used to be. At 26 years of age I have a lot of gray hairs I did not have two years ago. I sometimes wonder if it has made me less caring, yet at the same I can recognize a certain look people have in their eyes that says they are going through this same thing. I just want to grab them and say, "Tell me!" When I went through it, I assumed I was the only person who had ever had the problem.

INTERVIEWER: Would you like to be married to an agoraphobic?

SUBJECT: (laughter) Are you kidding! No! No! I don't wish this on anyone.

INTERVIEWER: Well, where do you plan on going from here?

SUBJECT: I would love to have a Master's in Music and have toyed with going back to school. But I would have to perform before a jury of the music faculty and I don't know if I could handle that . . . I don't want to come apart at the seams again.

Subject: Non-agoraphobic Husband -- 27

INTERVIEWER: When did all this begin with your wife?

SUBJECT: I was home the day, to my knowledge, that it started. She had just given birth to our son on Saturday morning; Was released from the hospital on Sunday morning and on Monday morning. I had taken off from my job to be at home that week because her mother could not be with her at that time. On that particular morning, I had fixed her a cup of coffee and at 8:30 or 9:00 she said, "My arm is going numb."

"What's going on" I asked her.

"I don't know, but I feel as though I am choking all of a sudden."

By this time she was very panicky. And here we are with a two day old wanting to nurse; A two and a half year old wondering what's going on. I called a friend to care for the kids and then called the ambulance for my wife. When the ambulance arrives, my wife has this paper sack over her head because she thinks she is hyperventilating. Looking back it seems a bit comical.

Arriving at the hospital, they ran several tests. "There's nothing wrong with you Ma'am." They then call her doctor who immediately prescribes Valium. Well, for a period of 3 days, she will not go to bed with a paper sack because she's still having the panic attacks constantly.

INTERVIEWER: Where to then?

SUBJECT: We then proceeded to go to four different doctors for treatment. One diagnosed her as diabetic. Later, a diabetic specialist overturned this diagnosis and said she suffered from a heart murmur. Another physician said she needed psychiatric treatment. Also, remember the first doctor we consulted was her regular physician and he simply prescribed the Valium and said "Don't worry. It will blow over." She seemed to be coping rather well and even took herself off all medication. Then, she went to visit a friend who had just given birth to a new baby and the moment she walked into the hospital room, all the old fears surfaced.

INTERVIEWER: The hospital room seemed to trigger memory of her own unpleasant experiences

SUBJECT: That's right. At this point, she knew for sure that whatever was wrong with her, it surely wasn't any of the things the doctors had diagnosed. Thus, she got off the medication and settled down to cope

with whatever was wrong with her.

INTERVIEWER: Summarizing things to this point, then, your wife sought out four different physicians and got four different diagnoses. Having been around the horn, so to speak, with the medical community, she has concluded . . . .

SUBJECT: . . . she concluded the doctors had no idea what was wrong with her! She has decided to take care of the matter herself.

INTERVIEWER: As of right now, she has no idea of what is wrong with her; is on no medication; and coping as best she can. How is she doing . . . just coping?

SUBJECT: At times she does quite well. At other times she does not cope with situations that she should be able to cope with. When some situations arise that are there to be handled, she simply dismisses them. She doesn't worry about those situations but simply dismisses them.

INTERVIEWER: She seems to have resolved herself to having certain limitations . . . .

SUBJECT: Right!

INTERVIEWER: You seem to be describing two women: a "before" wife and an "after" wife. Does this sound familiar at all?

SUBJECT: Yes. Before the problem started she was very carefree, almost flitty; very sure of herself, feeling she could handle whatever came up . . . no problem! She was outgoing and enjoyed being around people. Now, she has become somewhat of a recluse; not nearly as outgoing or as outspoken; not sure she can handle situations and steers clear of certain situations . . . especially those situations where she must confront another person. For example she will avoid confronting the parent of one of her piano students who simply is not paying their bill. She just will not call them and say "I have not received a check from you for this month's lessons."

INTERVIEWER: What about performing? Does she seem to steer clear of situations where she would have to perform?

SUBJECT: I don't know at this point how she would feel about performing. I don't know how she would react to a situation like that.

INTERVIEWER: How would you say all this has changed things at your house?

SUBJECT: Number one, the housekeeping is not as good as it used to be. She is more concerned, now, with the "inner person" than with worrying whether things are picked up around the house. Also, she has become rather quick tempered. However, this could be because we have two pre-school children. She has the tendency to fly off the handle. Of course she feels guilty afterwards and makes up for it.

INTERVIEWER: Would you say that this problem has invaded your personal relationship with your wife?

SUBJECT: I think it has. We are not as close.

INTERVIEWER: Is there less sharing between the two of you?

SUBJECT: Yes. I think there is some resentment towards me. And I have yet to figure out why that is. Perhaps, it is because I cannot comprehend what she has been going through. Also, I had to keep going . . . keep things running. I could not stop and wait for her nor could I devote full time attention to her problem. I don't thing she ever realized it was a full-time job keeping things running as close to normal. I always felt things has to go on as close to normal as possible for her to ever to work through the problem to a point where she would be able to handle things again . . . especially since we found out it was not something physiological.

INTERVIEWER: So you've devoted yourself to keeping things on an "even keel."

SUBJECT: Anything that looked like it might contain any friction or confrontation . . . I've handled. She has not known anything of our financial problems for the last two years; And going from doctor to doctor there have been numerous bills.

INTERVIEWER: So you have become sort of a protector, lest she become upset about finances. I wonder in what other areas you have assumed the new role of protector?

SUBJECT: My parents. They live right here in town but they have not understood her problem though we see them about once a week.

INTERVIEWER: Were your parents sitting right here with us at this moment, what might they say was wrong with your wife?

SUBJECT: I really don't know. I think they might say "she has been sick"; not knowing what that sick was. Or, they might say, "she has been neglecting her responsibilities."

INTERVIEWER: So there might be some animosity towards her, feeling she has not been holding up her end of the family responsibility.

SUBJECT: Uh, Huh. Uh, Huh. There are a lot of things I do FOR her. My folks react, "Why do you always have to do things for her!

INTERVIEWER: Have there been any other role shifts in the last couple of years since this all began?

SUBJECT: The children. I think I've taken over some of the work with the kids. She could not cope with getting up in the middle of the night. I've taken over that responsibility of getting up with the kids at night. Anything from 8:30 P.M. on, I have to get up and handle the

situation. Before, she would see that they were bathed and put to bed; Get up in the middle of the might when he was crying and get him a bottle.

INTERVIEWER: Have you any feelings about your new roles?

SUBJECT: No ill feelings. In fact, I think it should have been some of my responsibility all the way along but I just wasn't shouldering it.

INTERVIEWER: If you listed ten of the most critical events of your married life, would this be listed?

SUBJECT: This would have to be one of the top items. It would have to be one of the crucial events because it has changed our lives so. It has caused more friction between us than any other single item. On a scale of 1 to 10 I would rate it fourth from the top. I've probably spent $3000 to $4000 trying to get a diagnosis of what was going on.

INTERVIEWER: Sitting here today, do you have any idea what is going on with your wife? Do you feel comfortable in the knowledge you know what happened and why it happened?

SUBJECT: I have accepted the fact that she has a problem. I have constantly encouraged her to realize that she will be able to overcome whatever it is. I have never had any doubt about this because she is so strong willed. I am prepared for anything that might come up. No I do not know what has happened to her. I have just accepted it and am coping with it.

INTERVIEWER: How do you feel about the medical community at this point?

SUBJECT: I'm very disgruntled. To a large extent, they seem to have been so apathetic about her problem or so caught up in their own specialty.

INTERVIEWER: When your world has been turned upside down, as has yours, what coping mechanisms does one resort to? Also, who knows about your wife's "problem"?

SUBJECT: I know and probably the only other people that have any idea are extremely close couple. Also, we have lost some close friendships because of this. She did not want to talk about it and of course, our friends got their feelings hurt; They did not know what to say or what to ask.

INTERVIEWER: So your wife did not know what was going on inside her; you did not know what was wrong and your friends had no idea what the problem was. It's as though a game was being played -- something's wrong, but let's not talk about it.

SUBJECT: Yes. People would see her at church and respond, "Are you feeling better?" or "What's wrong with you?" What could she say -- "I'm chocking" or "I can't see you clearly"?

INTERVIEWER: If you and your wife don't talk about it a great deal, how then do you know when she isn't feeling well, or is having one of her episodes? Are there signals between you which lets you know the boat is a little rocky? How do you know to help or to back off?

SUBJECT: Sometimes I do know and sometimes I don't! If I don't know, I look back and pick up on signs that were there all the time. A sure sign is when she is more quiet than usual or when she has a tendency to yell at the kids; a preference for her to just take it easy. A sure sign is when she says, "I haven't been able to do anything all day."

INTERVIEWER: Does she ever come right out and say, "I'm had a bad day, etc.?"

SUBJECT: Sometimes. Very rarely does she come right out and say what the problem is.

INTERVIEWER: How then can your friends help you? Do You go right out and ask your friends to aid you?

SUBJECT: I did at first. However, this did not work out well because of lack of understanding on their part.

INTERVIEWER: For the most part, do you consider you and your wife as possessing the skills necessary to solve major problems that might come your way.

SUBJECT: Yes, Most.

INTERVIEWER: And what about solving this particular problem?

SUBJECT: I'm not sure.

INTERVIEWER: Have you come to accept this illness as a way of life:

SUBJECT: For the time being. I still say that she is better and will eventually become even better than she is now. She is 200% improved over what she was.

INTERVIEWER: If you will wait long enough, the problem will go away?

SUBJECT: Uh, Huh.

INTERVIEWER: Any special coping mechanism that have helped you to survive all this?

SUBJECT: Not really. I have come to depend more upon my religious faith to see me through. This has been a great strength to me. There have been times when I have not been able to cope with the situations so I have had to in essence turn it over to God.

INTERVIEWER: In addition to your faith, has there been a single relationship that has helped you through this?

SUBJECT: No (eyes tearful).

INTERVIEWER: So you have had to it alone?

SUBJECT: Uh Huh.

INTERVIEWER: Have you ever felt a need for someone to help you through this; Someone with whom you could talk and share?

SUBJECT: Probably every other day (eyes tearful).

INTERVIEWER: But they simply haven't been there for you . . . .

SUBJECT: Right! And that's tough to take.

INTERVIEWER: So, your wife has needed someone care for her. She has found no one else so you have tried to fill this need as best you can. You, then, have been giving to her, and no one has been giving to you. Together you have been trying to go through this thing alone. Is this correct?

SUBJECT: Yes, it it.

INTERVIEWER: If you had before you a group of husbands whose wives are about to experience a trauma similar to your wife's, what message would you like to share with them to prepare them and help them through the experience?

SUBJECT: I would advise them to reduce all outside interests and be prepared to spend 100% of their time and energies with their wife.

INTERVIEWER: Are you saying to make the agoraphobia the focus of their attention? Everything that is done, everyone that comes along is evaluated in light of the illness?

SUBJECT: Everything!

INTERVIEWER: What might you say to prepare them for feelings they may be experiencing?

SUBJECT: I would say, not to expect to receive the warmth and care they were accustomed to receiving from their spouse. There will be no time for that. The time of their mate will be spent on self. Don't expect to get any pampering, care and but very little physical response.

INTERVIEWER: So, the relationship is put on hold and all attention is focused on the problem? Would you say your intimate relationship with your wife has been affected by the agoraphobia?

SUBJECT: Uh Huh.

INTERVIEWER: Do your friends come over to visit?

SUBJECT: Not as much as they used to and not as much as I would like

them to. We spend a great deal of time at home in the evening.

INTERVIEWER: Can you see where divorce might enter the picture of an agoraphobic couple?

SUBJECT: It could very easily result. I can understand why either party might walk away from the relationship.

INTERVIEWER: Is there any particular "hump" you wish you and your wife could get over at this point in time?

SUBJECT: Yes, and I don't know how to describe that. I think it has to do with communication. The talking hasn't been there; The love hasn't been there and we have talked about this. We've stayed up late talking about it.

INTERVIEWER: Are you then conversing more about the problem or even finding it any easier to communicate with each other?

SUBJECT: I would say that our conversations about it are so heavy that we can't afford to talk about it very often. She tells me there is no way I can possibly understand what she is going through and I am in the same position trying to tell her what it is doing to me. There is just no way to explain it
for either of us.

I just can't believe it happened to my wife! She is such a strong person; she's not that type of person!

INTERVIEWER: How is your anger level at this point?

SUBJECT: It is getting better. Though an angry person by nature, I have been able, for the most part, to control my anger. Because of the feelings she has towards me and my feelings towards her, divorce has come up. Both of us state we don't want divorce! I'm not sure, but I feel she doesn't want divorce because of the kids, which is pretty hard for me to take. Because of this, it is at times more difficult for me to control my anger.

That she does not have the same love for me that I have for her does not change my love for her. She admits she loves me as the father of the two children; she loves me because we've been married 8 years but that romantic love is not there any more. I love her and will continue to love her regardless. My love for her is not conditional upon her returning that love . . . although it is difficult at time. She feels guilty because she is not the mother she should or the housekeeper she should be or that she cannot meet my physical/sexual needs any more than she can.

INTERVIEWER: Sounds as though you have a strong commitment to the marriage?

SUBJECT: Yes, but some days I wonder why. It gets pretty rugged. I know I cannot know what my wife has gone through but neither can anyone

else possibly know what I've been through with this. Seems like hell and back. The lack of sharing has been most difficult . . . no one to share with. You are wanting to talk with someone who knows something . . . someone who can sympathize and understand what I'm going through because they've been there -- a fellow sufferer. The mates of agoraphobics need to know someone else is facing the same thing.

The only thing that could possibly try a marriage more than agoraphobia would be the loss of a child. However, there is the promise of at least getting over the death of a child. In this (agoraphobia) every day is a new day and you don't know when you return home from the office what awaits you. The other day I found a note she had written about leaving me. She assured me she was just writing out her frustration. Still there is always that element of doubt that she will be there when I get home at the end of the day.

I have never shared any of her problems with my mother, but she senses something is wrong and keeps telling me, "hang in there."

APPENDIX G

INTERVIEW VERBATIM: FAMILY B

Subject: Agoraphobic Wife -- Age 25

INTERVIEWER: Where would the calendar begin for your agoraphobia?

SUBJECT: October 1981 was the crash-in point . . . when I cratered. I had just gotten engaged. However, in retrospect, I think it all began in the fall of 1979 -- my last semester of college. It was at that time I had a flu bug and was really sick. After that I had the trembles for about two or three weeks . . . almost like a decrepit old woman . . . .

INTERVIEWER: . . . any by "trembles," you mean . . . .

SUBJECT: I mean I couldn't even pick up change to buy a Coke, I was shaking so badly. I went to the University Infirmary and they ran all kinds of blood tests because they thought I was hypothyroid. All the lab work came back negative.

The further I get away from all that (in time) I can look back and see that I had the trembles but when I ate they went away and I calmed down.

INTERVIEWER: So a highly stressed Senior year at the University seemed to be the preface to your Agoraphobia.

SUBJECT: Right. All this business with the trembles seemed to be the beginning. At that point I was under a lot of stress in college during my Senior year -- Being sick the first three weeks of the semester and all the time trying to go to class with the shakes and not a lot of energy. This seemed to be the beginning. To make matters worse, I, upon graduation, moved to a larger town; couldn't find a job for the longest. This total stress lasted for over a year and a half for two years.

INTERVIEWER: Did you notice any changes in your feelings at that point:

SUBJECT: Well, just sitting here I noticed my hands getting warm and moist yet I did not have a compulsion to run out of the room. I have never run out of a room or left a place. Through it all, not knowing what was wrong with me, I determined to keep on going. I have just learned to sit there and suffer though the feelings of anxiety.

INTERVIEWER: . . . the anxiety of wanting to leave a room?

SUBJECT: Well, perhaps the feeling of not wanting to be there. Like I say, I have never had a feeling of "I've got to get out of here." I have anxiety just standing in a store or waiting in line at the check-out counter. Lines bother me.

INTERVIEWER: When are the bad times:

SUBJECT: Pressure situations. For example, it is a month away from Christmas, but already I'm anticipating the events of the holidays. I know I can get them done but it's the anticipation of them. Then there's the pressure of working out my career and trying to build my own business. I don't have the confidence in my own abilities and the insecurity of not knowing where to turn finds the pressure and tension building up. This sort of thing really throws me off.

Anticipated dates and events get to me. I can now go to visit my in-laws over in Arkansas without too much problem. It's a busy, happy, hectic loud household . . . two babies, two grandmothers and two mothers in law. If things get too hectic, I just go into another room for a few minutes; catch my breath then go back to the rest of the family.

INTERVIEWER: Is there a difference between what you were before all this started and what you are today?

SUBJECT: Definitely. Previously, I was always busy; chairman of committees; a leader in school and participated in public speaking contests. In general I was outgoing. I was constantly on the go. I remember a conversation with my room mate where she encouraged me to stay home one evening rather than go to a particular meeting, but I felt compelled to be at the meetings. I did enjoy them. I loved it. I even thrived on it.

INTERVIEWER: So you could be characterized as a busy, outgoing and involved person before the agoraphobia. Were you a confident person at that point?

SUBJECT: Yes. Very much so! I was little Miss Involved.

INTERVIEWER: This was the "before" side of you. What about the now side of you? What happened to the confident you?

SUBJECT: The confident me is coming back. Yes, she is coming back.

When it first hit I was feeling a fear and didn't know why. I felt transparent and had difficulty dealing with friends face to face because I was just sure they could look right through me and see everything I was feeling . . . all the insecurity and fear. One to one encounters were horrible.

INTERVIEWER: What if they could see right through you and know of your fears and insecurities. So what?

SUBJECT: I just knew they would think less of me. Since I didn't feel very strong, I was afraid they would not think of me as a strong.

INTERVIEWER: So you started hiding it?

SUBJECT: Oh, sure. I was a pro. All of us (agoraphobics) are pros at hiding it.

I remember one day in particular I had a really horrible day at work and just needed a place to get away and I needed to be with someone I knew. I went to this good friends house at noon and told him of my agoraphobia and the need to relax and be with a good friend before returning to work. He just couldn't believe it! He said, he had never thought of me as a nervous person. I kept telling him it wasn't a matter of being nervous--I am not a nervous person. You will never see me fidgeting, biting my nails, wringing my hands, pacing the floor. He wouldn't believe anything was wrong with me.

INTERVIEWER: If you are so calm and composed on the outside, what's going on inside?

SUBJECT: Pure hell and havoc! That's right! It was a kind of hell.

There was a period of three months of my life, at the very first, which I call my, "black period." If I try real hard I might remember the sun shining for a day but it was predominantly black. It was such a panic. It was like something was going to eat me up and I'm going to disappear. At times I wished I would just dissolve. I used to think that all the time. I wished I could just go "Poof" and be gone.

INTERVIEWER: Is it shaky just talking about it?

SUBJECT: Well . . . Yeah . . . there is a better way to put it. Let's say I feel vulnerable and it's a tender area. Afraid to talk about it for fear that those feelings will come back. Those feeling hurt so much. They used to scare me. For ten months I was out of it.

INTERVIEWER: Any idea of what was causing all this to go on inside you?

SUBJECT: I've been going to a Chiropractor and he gave me a brochure on Hypoglycemia. During my black period I was drinking at least ten cups of coffee every day at work plus eating doughnuts. Then I would eat a candy bar about three O'Clock in the afternoon. The caffein and sugar had me wired.

INTERVIEWER: Any physical symptoms accompany the fears and anxiety?

SUBJECT: When I was working for Sun Oil Company and would get off the elevator, my legs would get weak and tingle. My arms would begin with numbness. At this time I had mononucleosis and was tired all the time. Still I continued to work. About this time I began experiencing the feeling of "rotation" -- a floating sensation upon lying down and closing down. The sensation was so powerful that I was afraid to just let go and go with the feeling of floating for fear that I would float off into the night air and never be heard from again. I did not know what the conclusion the floating feeling would be. So I would usually sit up and walk around the house to get away from it. The floating feeling usually happened at night.

INTERVIEWER: Did you seek any professional help at this time?

SUBJECT: I went to a neurosurgeon who tested me for equilibrium but couldn't find anything wrong with me. I also went to my regular physician and he prescribed Librium, 30 mg. per day. I usually took only one a day and when I was anticipating a stressful event. I don't think they actually did me any good but proved to be more of a security blanket. They could well have been a placebo and probably done as much good. He also prescribed Triavil with the Librium.

During this same period I began experiencing Vertigo. I had a lot of that. It was as though the whole room was vibrating. This was the time I began seeing a Psychiatric Nurse. She was really good. I would wake up every morning with the room shaking around me and go to bed with the room vibrating.

INTERVIEWER: Okay. So you sought professional help in your physician, a neurosurgeon and a psychiatric nurse. Did you find help in understanding what was happening to you?

SUBJECT: This was really quite frightening. I did not know what was happening and they could not help me understand. There was nothing to grasp or to explain it.

INTERVIEWER: If they did not know what was happening to you, what did you think was going on inside your head?

SUBJECT: I really didn't know. It was so frightening. I didn't think I was going crazy until October of 1980. That was when I got engaged and the agoraphobic symptoms really hit hard. I don't know. I couldn't figure out what was happening to me other than perhaps that I was a weak person. I would always turn to God and pray for strength and cry, "I don't want to be like this!" I would hurt until I was exhausted. I had enough psychology courses in college to know I wasn't psychotic or schizophrenic. I knew I wasn't going crazy yet I felt like I was.

I found some pages in my journal of January 1980. I had mimeographed several pages of an article about Anxiety. The pages also included portions of an article on Agoraphobia. I noticed last week that most of what I had underlined was in the article on Agoraphobia. All my yellow highlighting was under the symptoms on Agoraphobia. I don't know why to this day it never sunk in to explore this business of Agoraphobia, but I didn't.

INTERVIEWER: Any special ways you adapted your life to cope with the agoraphobia?

SUBJECT: At that time I was a member of a rather large church and I was feeling uncomfortable, so I transferred my membership to a much smaller church and felt more at ease in church services.

Also, I began attending the seminar on Agoraphobia conducted by a Clinical Psychologist who specialized in Agoraphobia. I began to learn how to relax and cut down on my medication.

INTERVIEWER: Are you currently on any medication?

SUBJECT: No. I have not had any for a year now. After my prescription ran out I decided not to refill it. I feel really good about this.

INTERVIEWER: If you listed the top ten events or happenings of your life, would the agoraphobia be listed in that group?

SUBJECT: Definitely! What has happened to me in the past two years will shape and determine how I live the rest of my life.

When I was a little girl, my dreams and aspirations were college and marriage; that encompassed it. That's as far as I went in my thinking. I had never had any goals or any strong motivations. All that is different now. It is as though somebody threw cold water in my face and I have been reborn. Things are different now.

INTERVIEWER: What about your relationships during the agoraphobia?

SUBJECT: The only one I felt safe enough to have a relationship with was my fiancee. I tried to tell my parents but they really wouldn't respond on the phone. I know they were concerned but were afraid to say anything lest they upset me. They did not know how to respond to me. I got really frustrated with that. I really needed security. I couldn't take it any longer and finally one night I shoved my prescription drugs in his (fiancee) face and said "I'm taking these pills, going to see a counselor because I'm agoraphobic!" His reaction was "Okay. That's fine." He did not even bat a lash and has been so supportive.

INTERVIEWER: Personality-wise, are you any different?

SUBJECT: Anger. Yes, I get angrier now or I allow myself to get angry. Today, I flipped a bird to a guy who nearly ran me off the road. Previously, I would just let it pile up inside me.

INTERVIEWER: Any particular person or thing that gets to you and makes you angry now?

SUBJECT: Myself. The thing that makes me most angry now is when I go through periods of anxiety. I will be going along so smoothly and then I will have a bad week and that just burns me up!! I will go for weeks and think "Gee, I'm doing so well" and then it comes along. I get angry at IT! The agoraphobia.

For the first time in my life I can have a disagreement with someone and not feel badly about it. My husband has really helped me with this. He told me when we first got married, "Listen, you can yell at me and I'm not going to leave you." Inside myself, I was always afraid if I yelled he would just walk off. All my life I've hated hurting anyone else; I've never wanted to hurt anybody. I had people treat me terribly and all I could think was, "What have I done?"

INTERVIEWER: How would you like to live with an agoraphobic?

SUBJECT: I can't believe my husband married me knowing I was an

agoraphobe. He knew it and still married me. The amount of love and strength he gives astounds me.

INTERVIEWER: So he is very supportive . . . .

SUBJECT: Yes and has always been. Today at lunch I was trying to think of any time when I had ever felt any impatience or exasperation from him to the point where I was sorry I had expressed any of my feelings towards him and I couldn't think of any.

INTERVIEWER: So at no point have you ever questioned his love or commitment to you or your marriage?

SUBJECT: Never! The only doubts have only been in my own head. When I first married I thought of divorce as a way out for my because I was living from day to day. I would think "O my goodness what have I done! What have I done to him? Do I really love him? Did I marry him because I was sick and needed somebody? Most of the time it was "Do I really love him?" Not having a strong hold on myself I didn't feel qualified to define anything as "Real" outside my own feelings.

INTERVIEWER: Have you worked through all these feelings?

SUBJECT: Yes. It was just a matter of time and a matter of my getting better and learning how to get better. I'm feeling confident. Living with him and realizing that he wasn't going to walk out on me has gradually helped me to express an aggravation with him that has helped me to release aggravation with other things in life. I just got them out of my system. I learned to trust him. Trust and security, that's it.

INTERVIEWER: When you are going through a bad time, do you tell him or does he have to guess or do you have "signals" to communicate that you aren't doing so well? Are you up front with him?

SUBJECT: Uh Huh. I usually tell a few days later only to have him say, "I thought so." He has come to know me really well and even when I have a low- key attack he can sense it.

INTERVIEWER: What does he do that is so supportive in the bad times and makes it easier for you?

SUBJECT: I am learning to say, "Hey, I'm really tense." He is really affectionate and we are very huggable, snuggable. I need all that. The touching and hugging has pulled me through. Sometimes he will just hold me. At other times, after a rough day at work we will come home, put on our jeans, lie down on the bed and just talk for an hour or so before we get up to fix supper. I have been able to tell him just how I was feeling or what the day was like. He tells me about his day and if I have had a bad day I may have a good cry and he will just hold me until its over. There is a lot of touching, holding and talking.

INTERVIEWER: Would you say the agoraphobia has gotten in the way of your relationship with your husband?

SUBJECT: Mmmmm. No. I really don't think it has. I'm sure it has been stressful to him at times and I'm sure has felt some impatience at times, but he has been so good not to convey those so strongly to me. There has never been that, "I don't understand what's going on with you. Why don't you straighten up and get better!"

INTERVIEWER: If I had ten men in this room and were getting ready to marry an agoraphobic woman, what would you like to tell them to clue them in on what's in store for them?

SUBJECT: Speaking strictly from my own perspective, I would tell them that what works for me is to let me know if invited somewhere, "If you want to go we will go and if you get nervous we will leave." Tell them to touch a lot. But of course there will be times when their wife will feel trapped and touching may be uncomfortable but they should not take it personal. I would tell them to listen . . . just listen. Sometimes we need to talk to our husbands.

INTERVIEWER: Any social limitations these husbands need to prepare for?

SUBJECT: Sometimes we may hibernate. At other times we need to choose the activities or events we want to participate in. I don't feel bad about this any more because for so long I forced myself to go along and it caused so much pain that I don't do it any more. I know my limits now.

INTERVIEWER: What's the number one situation you try to avoid?

SUBJECT: Really emotional situations. My own emotions are getting stronger but I am moving slowly. I hit bottom at times but I am working my way back up. Some day I will be there. But now I'm not involved with that many people any more, so I don't have to deal with many people relationships.

INTERVIEWER: Who knows about your problem? Earlier you said you had tried to hide it from people and protect (husband's name), but who knows now?

SUBJECT: My parents know but his parents don't know. Probably the turning point in this whole thing was the sunday I confessed to the entire church that I had Agoraphobia. The church has always been important in terms of how I define myself so this admission to them was difficult. Since I was no longer a leader I was feeling all sorts of guilt. But there was such a relief the sunday I told the entire congregation I had a problem handling social situations. Following that episode I got to know several people in the congregation. I felt freer to be open about it with them. My self-confidence really went up. Yet, out of the entire church, only one person has come up to me and asked me about my agoraphobia. Out of 300 people who heard of my agoraphobia that sunday, only one person as come up to me and talked to me about it. And that was a man who was curious about fear because he had never experienced the emotion of fear ever in his life except for he time he nearly flew an airplane into the ground and he thought he was going to

die. But he said several of his friends had spoken of being afraid and he could never comprehend being afraid. He is the only one to come up to me and talk about my fears openly.

INTERVIEWER: It is safe to say that when you stopped trying to hide your problems and was up front with people, you started improving?

SUBJECT: Yes, this was a major step in my improvement. I have become quite open anymore.

INTERVIEWER: Do you feel a person who has never had a panic attack can ever understand a person who has had one?

SUBJECT: No. You could describe the panic attack to them and multiply the intensity fifty times and then they have only a hint of what it is like. The panic attacks are so charged.

INTERVIEWER: Have you found your friends to be supportive and encouraging?

SUBJECT: We don't talk about it with friends. I've tried to talk about it with a very close friend but he steers clear of the subject. Another girl friendly, I tried to share it with her but she never got the point. So there are only two people I've told and talked about it. I've tried to bring it out in conversation but no has caught on and asked me about my problem. I don't think anyone ever listens to what anyone else says. It has become a game and I even test people by telling about my agoraphobia to see if anyone would inquire further or ask questions . . . no one does. The only person who has asked me has been a woman who cornered me about the panic attacks was a woman who is struggling with agoraphobia herself and has no one to talk to.

INTERVIEWER: Why do agoraphobics make a major issue of hiding their problem?

SUBJECT: Fear. Fear. People might think we are weak. Less than what we should be.

INTERVIEWER: Do you think you are ever going to get this thing behind you?

SUBJECT: Well . . . I keep getting better. It's been two year since it began; I've quit my job and now free-lance because of the agoraphobia. It has played havoc with my self-confidence. I still have difficulty thinking of myself as an interior designer worthy of $25 an hour. This really causes tension. I still feel rather fragile at times.

Subject: Non-agoraphobic Husband -- Age 33

INTERVIEWER: When did you come to discover some of the real challenges your wife faced with the problem of agoraphobia?

SUBJECT: I remember that while were just dating, she came to me, handed me a bottle of prescription drugs and said "I'm taking these tranquilizers and seeing a counselor."

INTERVIEWER: Did you think any less of her for her having this problem and using medication and seeing a therapist?

SUBJECT: Oh, No! As long as she was working with a physician and trying to work through this thing . . . I feel now kinda down on doctors. I don't know just how many she went to but they each told her a different story about what was wrong with her. They didn't help. It was either this problem, or that problem, but never the right solution . . . "You need to take this pill or that pill." Looking back it seems fairly obvious what was going on with her. I remember reading a single article in the newspaper (on agoraphobia) and saying, "that sounds awful familiar." So I get down on doctors occasionally, because I wonder why they didn't see this.

INTERVIEWER: What was the first indication that something was wrong?

SUBJECT? I remember while she was driving the car and suddenly she got afraid.
She got white knuckles on the steering wheel. Later there were numerous instances where she would start crying. I would come home and she would be in tears.

INTERVIEWER: What must you have thought when all this behavior began?

SUBJECT: Well, I attributed it to her being more emotional than most women . . . or the term my mother uses--"she's high strung."

INTERVIEWER: And the way you dealt with these emotional outbursts . . .

SUBJECT: Well, I would hold her and tell her, "It's going to be all right. The fears typically aren't real . . . it's just something you are afraid of." And I would share that I have felt feelings of fear at times . . . in crowds or speaking before a group; most people go through, but most people don't let it build or snowball on them.

INTERVIEWER: What particular situation does your wife avoid?

SUBJECT: Most recently, she had a real problem going with on a weekend

outing with about 60 other women. Her fear was, "What if I'm out there away from home and start to have problems? What will I do?" I could feel her tensing up two weeks before the weekend ever arrived. I can feel her tension building and building.

At this point, being away from me seems to work a real hardship on her. Three or four months ago, I left for a business trip for a few days. She had a terrible time . . . terrible time. Sometimes she will 'freak out' in church and we will have go get up and go outside for a few minutes, then we will go back in.

INTERVIEWER: How does one handle that kind of dependency from the spouse?

SUBJECT: It concerns me that the dependency continues as strongly as it does. I am trying to be less of a shoulder. I am going to leave on business trips occasionally; she is going to have to leave on trips occasionally and I don't want to have to worry about her when I'm not there. She is still so attached and I tell her she is going to have to get used to it (my being away from her). This is part of the problem right now -- I've been a crutch for quite a while now for over two years. It concerns me that she should be getting stronger . . . and I think she is.

She lost her job several months ago and I've been pushing her to get out and continue to do things--"Continue to work; Seek out jobs; You can talk to these business men . . . there is no problem." And occasionally she gets mad at me pushing her, but I'm pushing her intentionally. I want her to get out and learn it. She can do it. She gets mad at me every once in a while with "Don't push me!" And I back off for a while or push her more, depending on what I feel needs to be don, because I want her to be able to do that and not rely on me all the time. I have to think of what if I'm killed in a car wreck? What will happen to her? I want her to be able to stand on her own feet. It's hard to find that like between providing security and pushing her out to try out her own wings.

INTERVIEWER: What might this kind of dependence do to a relationship?

SUBJECT: Well, it has tried my patience. I feel I am a fairly patient individual but at times I want to shake her and say "Get out there and do it! It's all in your head! What is upsetting you is not real and it will not hurt you. So your let hurts? All our lets hurts at some time or another but you let it build until you are wondering if its a blood clot."

At times I want to yell and scream, "It's all in your head!"

INTERVIEWER: But you don't scream, "It's all in your head!" and you don't yell . . . .

SUBJECT: No. No. I say "I understand " and whatever needs to be done I do it and it will soon go away.

INTERVIEWER: I'm wondering why you don't yell and scream?

SUBJECT: It would but hinder the situation. I don't have any problem with anger but when it was really bad at first, I was closest to being angry.

INTERVIEWER: Can you tell when a bad spell is coming on?

SUBJECT: What's bothering her usually begins so small and then takes a while before I see it. I am often all wrapped up in my own world that I don't see it until it gets close to being bad. It's hard . . . it's just hard.

INTERVIEWER: But when it does get bad with her and 'push comes to shove' . . . where do you go from there and what do you do then?

SUBJECT: I hold her, listen to her cry and say "It's going to work out so go on and cry it out." I really don't do anything but provide the shoulder. But she is doing real good . . . getting out and doing things. I think the hardest part for a long time was keeping her out and doing things instead of staying at home. She did not want to get out and look for a job and it was hard to push her out without it backfiring on me.

INTERVIEWER: If you were to make a list of the major events in your wife's life, thus far, would the agoraphobia be listed?

SUBJECT: Oh. Yeah! It would be right up there near the top. It has made a major difference in our relationship. Right off our relationship was close and intense since she was so dependent on me. Part of the problem now is I'm trying to wean her from being totally dependent on me. I want to remain close but not dependent on me.

INTERVIEWER: What, if anything, has helped you to cope with the malady?

SUBJECT: I attended classes for Agoraphobics and learned a lot about handle her fears as well as giving me insights as far as why and what is happening. Then I felt I understood a little more and could deal with it a little easier. Reading the books on Agoraphobia has helped.

INTERVIEWER: If we could split her right down the middle and look insider her head and heart, what do you think we would find inside that woman?

SUBJECT: I think we would find a lot of insecurity. She is always so surprised when she sees she can do things -- like a child discovering he can do certain things.

INTERVIEWER: Do you think you would be happier if she suddenly got rid of the Agoraphobia . . . be cured today, right now?

SUBJECT: Yeah, I think so. But there is part of me that feels good that somebody needs me. I have often thought, Do I want that person to get better? There is a part of me that feels good to have someone who

needs me. When people get better there is chance they won't need us anymore and I wouldn't want that person to get better because he would quit needing me. I know this has to be back in the mind somewhere. If she gets rid of it, will she still love me? I don't know but I assume so; Will she still need me as much? Probably not.

INTERVIEWER: This has crossed your mind, then?

SUBJECT: Yes. But in answer to your question, Yes I want her to get rid of it and be the healthy, outgoing and energetic person she is.

INTERVIEWER: You married her, knowing all this. It wasn't as though you woke up one morning and said, "You didn't tell me about this when we were dating."

SUBJECT: I knew full well. She needs me and I need to hang in there. I love her very much so I'm going to help her as much as I can. I'm going to do whatever I can to see her through this. If it costs me money, fine; If she needs a shoulder to lean on, fine. Whatever, I'm going to do it. It doesn't cross my mind that I can back out and walk away. I don't think there was ever a time when I thought 'This is too crazy for me, I'm going to leave'. I'm too much wrapped up in it and very much in love and besides this is what I'm here for.

Yes, I've been angry and impatient and at times . . . . But, I made a vow that says whatever her problem is I'm going to be right here. It is kind of irrelevant whatever her problem is, I'm in this relationship to stay.

INTERVIEWER: That has to be a pretty solid feeling for her to know you are 'here to stay' and not going to walk out.

SUBJECT: I hope she knows this. It just really doesn't matter what the problem!

INTERVIEWER: Sometimes I get the impression that in a marriage where one spouse is agoraphobic, the relationship is a one-way street of giving . . . one does all the giving and the other does all the taking; The entire marriage centers on the agoraphobia.

SUBJECT: Several times I've thought, "Hey, I've got this, this and that going on in my life. I need somebody for a shoulder." Many times I've wondered, "What about me? I've got problems, and feel like crying, too." But I couldn't do that. I couldn't say, "I need to talk" because we were focusing on her needs or when I came home upset, she was already crying.. Even when she is doing okay, I tip-toe around for fear of upsetting the apple-cart.

INTERVIEWER: Let's assume she gets back to her old self. Fantasizing this for a while, let's assume out of the clear blue, your wife is cured; her self-esteem is back, her confidence level is raised to its previous level and she is back to her old self. What are the implications of this for your marriage?

SUBJECT: We would probably not spend so much time together. I would not feel the responsibility of needing to be there constantly. Hopefully she would be out doing things and we would be able to go our separate ways with more individuality. I see our relationship as being closer than most because I have to be available. I cannot go out with he boys a lot of the times because I feel the responsibility to be there with her.

I would like to see this change come about (i.e. her return to health). I would like to see how she could do in a career. Perhaps she could even help out financially. That is also an area where I have felt a burden in that we have to rely on my income solely. When we married she was working. With the Agoraphobia, however, she quit her job and is now doing some free-lancing work. There have been times when I would like to have told my employer I was quitting because the conditions were so bad but she wasn't working, so I had to stay on the job. I was in a bad situation that was driving me crazy and I needed out. But being the sole breadwinner, I remained on the job.

INTERVIEWER: Who knows about the agoraphobia?

SUBJECT: Very few people know. Her parents know and the people at our church know because she shared it with them one Sunday morning during services.

INTERVIEWER: If I had several men in this room with us who were preparing to marry a woman with agoraphobia. What would you tell them to help them get through the rough times.

SUBJECT: I sure hope they are patient. Tell them they cannot make it any better by yelling. All they can do is to hold her, work with her, listen to her and try to help her work it out.

INTERVIEWER: What can you tell them about handling their own frustration?

SUBJECT: Make them understand they must be willing to make the commitment. They must be willing to invest heavily because they will not be getting anything in return for a while. It will be a lopsided relationship because you will be the primary giver.

Help them to understand that most of the things (about agoraphobia) don't show. Unless they are really in tune with their wife they will not see what's happening to her. It is possible for their wife to be going through a panic attack and no one ever know it.

INTERVIEWER: Living with the agoraphobia, has all this changed you?

SUBJECT: I don't think it has. I'm sure I'm stronger. I've live through it once and could probably live through it again . . . . I think I could.

INTERVIEWER: What are some of your needs? For two years, now, you have been the mainstay in the marriage And what are some things you

need form your wife? What do you need right now.

SUBJECT: Six months ago I was needing to do the crying because of a lot of insecure feelings as a result of my own career path. I needed to be held. I would like to be able to do that occasionally. There are times when I need to lean on someone. I would like to think she was strong enough to let me lean on her for a while.

INTERVIEWER: Are there any words you like to hear from your wife?

SUBJECT: I don't know. Perhaps I would like to hear her say she would be a little more assertive . . . especially in a career sense. Other than that, she is meeting all my needs and I don't have any complaints. Her constant leaning on me isn't all bad as I feel wanted.

I think we have a very good relationship and perhaps it is due to all this and what we've been through. We've had to grow up real fast and learn a lot about each other quickly.

INTERVIEWER: Ever had to make an excuse for your wife because of the agoraphobia?

SUBJECT: No. Some of our close friends know and others know something is wrong; they don't know much but they know something is wrong. I can very easily say to others that she has anxiety and usually you don't have to explain much further. I don't feel a need to explain to everybody but she shares more freely with people. In my opinion is no one else's business what's going on with us.

INTERVIEWER: Any last word to people married to agoraphobics?

SUBJECT: (laughter) Tell them I'll be praying for them. Seriously, it is a long haul and I hope there are no relapses (for my wife). She seems to be doing so well and I'm afraid it will resurface. What I've learned that has helped me deal with her is that though the fears aren't real to me they are to her. It's tough . . . tough to handle at times.

INTERVIEWER: Do you think, then, the agoraphobes can help being the way they are?

SUBJECT: We all have crises and anxiety but most of us do not let it snowball like they (agoraphobes) do. I don't think a normal, strong person would allow the agoraphobia to happen. I don't think I could ever let it happen to me because I'm not going to let that fear conquer. I think this is why you see more women than men have the agoraphobia. Men by culture are trained to be stronger and if they do have fears, shuffle them under. I think it has to do with your psychological make-up.

I have seen other agoraphobics who have been devastated by the problem. They may as well have had cancer . . . it's inoperable; They were functionally at a vegetable state. They were totally dependent on others to drive them places because they could not do it themselves. That' sad . . . really sad.

INTERVIEWER: Do you want to own up to any feelings about these 'vegetables', especially the men who were dependent?

SUBJECT: I feel a lot of pity for them; Like you would for any person with a disease. In some sense I thought they must be weak - like alcoholics having a weakness they can't control. It is my feeling there is something weak in them and this is the reason they are like that.

INTERVIEWER: In other words, if they would just grow up and accept the responsibility of living, they would get better?

SUBJECT: Yeah.

APPENDIX H

INTERVIEW VERBATIM: FAMILY C

Subject: Agoraphobic Male -- Age 33

INTERVIEWER: Do you have any memory of when the agoraphobia began?

SUBJECT: Things like that get etched in your mind forever -- July, 1973. I was driving up the Will Rogers Turnpike to visit my folks and I began to have the symptom of entrapment. The turnpike is a limited access road and you just don't drive off of it and go back the other direction. You actually get penalized for doing that.

INTERVIEWER: What happened then?

SUBJECT: I began to have shortness of breath with extreme feelings of uneasiness and heart palpitations -- classic symptoms of a panic attack. It was a terrible feeling. I continued to my folks house and told them about it and we quickly dismissed it as 'coming down with something' and simply not feeling well. This was the beginning and from that time on the panic attacks happened with greater frequency.

INTERVIEWER: What did this do to your life?

SUBJECT: It became very difficult for me to drive on the highway. And for years it was like that . . . even today. A traumatic experience. In fact, a couple of years ago before I began attending the Agoraphobia Seminar, this was one of my major problems. I could handle driving around town but it it not at all uncommon for agoraphobics to become "city-bound." Whereas as along as you are operating within the city limits, things feel pretty good . . . you can do it although it puts quite a bit of pressure on you but you can do it. When you get out of the city limits, you start having trouble. I was like that for years.

SUBJECT: What about your driving in town . . . any difficulty?

INTERVIEWER: Even in town I would route courses. Say, I had to go over to a printers to check on a job, I would figure our a course to that printers shop that would take me by the closest hospital, fire station or a place where I could get in and get help if I needed it -- All because of the fear of the fear attack itself.

INTERVIEWER: What must you have thought was happening to you?

SUBJECT: First of all, I did not actually know what was happening, so I feared I was dying. These attacks were signalling that death was near. I felt like I was actually trying to die because it was such an incredible explosion of horrible feelings. I associated it with death. I associated all the alarms turning on inside me to call up all the reserves to keep me functioning, to keep me breathing, to fight the

inevitable death.

INTERVIEWER: Any other thoughts associated with these frightening feelings?

SUBJECT: Yes. Later on there were feelings that I was going crazy. Theses were helped along by . . . I went to doctor after doctor trying to find out what was wrong. Doctor after doctor told me nothing was wrong with me. After a period of time, through a period of elimination, I concluded I must be going crazy. They said there was nothing physically wrong with me. The best physicians in this city checked over every inch of my body and tell me there is nothing wrong with me physically, so I concluded something mentally was wrong with me. That (being crazy) was the only thing left. This actually help build the thought in my mind that I was suffering from a mental disorder. Then when I really got confused was when I went to psychiatrists and they told me there was nothing wrong with me. They had never heard of this (agoraphobia) before. They tested me for the classic symptoms of Schizophrenia and mental disorders and they concluded there was nothing wrong with me. Then I was thoroughly, totally confused about what these feelings were, and all the time they were getting worse. It was getting more difficult to do the things the rest of the public seemed to be doing with ease.

INTERVIEWER: Surely, this has an impact on an individual?

SUBJECT: It is a very slow tear-down process of self-esteem. Energy level slowly collapsed to nothing. I would come home at six O'clock in the evening and collapse, literally collapse into the bed. No supper. Sleep to ten o'clock, get up and eat a little bit and drop back into bed. Get up the next morning and fight it all day long . . . .

INTERVIEWER: . . . Sheer exhaustion . . . .

SUBJECT: . . . Absolutely! Mental and physical (exhaustion). Mentally, I was exhausted from fighting the possibility of fear attacks . . . . I was having up to ten attacks a day. Physically I was exhausted from the tension, tight muscles, pain -- there is a lot of pain -- physical pain. I still suffer a lot of pain from tight chest muscles that are really tight and drawn. Just like the burning sensation you get from walking up a long flight of stairs. It is constant! It is a very unravelling feeling constantly being in pain -- maybe even all day.

INTERVIEWER: At any point were you put on medication?

SUBJECT: Yes. A low dosage of Transene, prescribed by my general practitioner for the chest pain. After I had been thoroughly checked out and assured there was nothing wrong with my heart, I was prescribed the Transene to help with the chest pain. I still have Transene available to me though I rarely take it.

INTERVIEWER: But it is good to know it is there?

SUBJECT: Yes. It is kind of like the character in the Charlie Brown (Linus) cartoon that drags the security blanket around. It is good to know that if it is needed it is there. It is not a habit-forming type of medication. I think a lot of agoraphobics get to where they worry about everything, including a dependency on drugs. You become oversensitive to your body -- including hurting it. The thinking behind this is "I'm already hurting enough so I don't want to get started on anything else that will make it worse."

INTERVIEWER: You said you had been to doctor after doctor after doctor. Would you hazard a ballpark figure about how much you have spent trying to get a handle on what your problem was?

SUBJECT: I would say that in the last ten years my wife and I have spent $15,000 on treatment. This is an honest estimate. I feel very comfortable with the accuracy of this estimate. I would say I am eighty five percent cured of agoraphobia and in 1983 I spent over $2000 treating a secondary symptom of agoraphobia -- Depression.

Because of the terrific amount of pressure, it is very easy to fall into the trap of depression. Because of the panic attacks, you develop secondary problems associated with the primary problem. I have spent $2000 in depression therapy just trying to ward off the secondary problem and everything that goes along with that.

INTERVIEWER: If we were describing yourself before July, 1973 and after July, 1973 . . . what would be the difference?

SUBJECT: Before I was a much happier person. Self-confident. I was 22 years old and just out of college. I graduated high in my class. I was proud. Proud of my achievements all the way along -- including, my high school and college career. I was happy with myself. I was looking forward to stepping out of the educational phase of my life and getting into the rest of my life with the beginning of a family, the beginning of a career. I was really looking forward to that.

INTERVIEWER: Were you married at that time?

SUBJECT: No. (My wife) and I got married a year and a month after my initial attack.

INTERVIEWER: Who all knows?

SUBJECT: Well . . . a lot of people know . . . . There is only a handful of people . . . a relatively few . . . probably not over two or three people that really, truly know . . . maybe four or five. A handful of people know the pain that is associated with the agoraphobia. A lot of people know I have agoraphobia because I have mentioned it to them but they have no idea of the pain associated with it. I assume they associate Agoraphobia with . . . like Claustrophobia or common phobias they have heard about or a wide swath of the general public would know about.

INTERVIEWER: Do your parents know?

SUBJECT: Uh huh. But, again they have no idea . . . . I've never really shared with my parents they day in, day out struggle. They know about it, but they have no idea of the amount of money, for instance, that I've invested so this thing would not totally get a hold of me and drag me clear down.

INTERVIEWER: Do your in-laws know?

SUBJECT: Uh . . . No. I don't think they know anything about it.

INTERVIEWER: If you were listing the top ten events of your life, would the agoraphobia be included?

SUBJECT: Number One! There has been nothing in my life that has had the effect on my that the agoraphobia has. I'm being factual here, not dramatic at all.

INTERVIEWER: To a person sitting here, who has never even heard the word Agoraphobia, how would you describe the feelings involved?

SUBJECT: This is a very difficult question. I've never really put in a single sentence what it is like.

It is the most intense feeling that I have ever felt in my life. I have never had feelings in my body that have scared me or made me feel any more uncomfortable that I have felt with the feelings associated with agoraphobia . . . ever. And I have been in two automobile accidents, a motorcycle accident. I have felt physical pain and I have felt emotional suffering from losing loved ones in empathy for others that have been very intense. But these cannot compare with the feelings associated with agoraphobia. These are the strongest, most uncomfortable feelings I have ever felt . . . ever.

If I were sitting here with a little electrical plug attached to my finger and you told me that you were going to plug the other end of that plug into a socket and I could experience Hell, I would say I have already been there and felt what Hell is like. I think this is an accurate statement. Hell is the most awful thing imaginable and to this point in my life I have not felt anything more 'hellish' that I have felt in agoraphobia.

INTERVIEWER: Earlier you gave the "before" side of yourself (i.e. before the onset of agoraphobia). What is the "after" side of (subject's name)?

SUBJECT: For twenty-two years life had been building up for the good. Then in 1973, it all began crumbling away and finally collapsed in 1978 and 1979. Where before I had feelings of high self-esteem and pride . . . they all crumbled and eroded away. I became introverted, scared. I was convinced there was something terrible wrong with me. I became depressed and non-communicative. I avoided almost all outside situations.

Before I was just the opposite. Agoraphobia tore down in a short amount of time what had taken 22 years to build. Since that time, the last three years I've worked hard to try to regain what I've lost. And I'm still working on it. I just want to get back to 'even ground'. Every agoraphobic I've ever talked with just wants to get back to 'even ground'. They hold out the hope they can recover the ground they've lost. That's what we are clawing for -- just to get back to where we were before.

INTERVIEWER: But, should you get back to this point of 'even ground', where would you be?

SUBJECT: Well, I would have my self-esteem back . . . the feelings about myself would be so much better. Hopefully, a lot of the fear would be gone. As long at that fear-of-the-fear is there it's awfully hard to deal with the everyday pressures of everyday life.

Then, too, you get into the problem that there's a whole bunch of people out there that don't have our problem and don't know what we're going through. This is a competitive society. There are people competing for my job right now. That's the way life is. Agoraphobics carry a double load and they go up the same hills everybody else does. I would just like to get half the load off and get back to where everybody else in the world is -- back to where I was in 1973.

INTERVIEWER: Basically, you said no one knows about your agoraphobia, outside of your wife, your former employer and myself? People just don't know about your problem. Why?

SUBJECT: Agoraphobics try to withhold the inevitable of finally leaking it out to whomever -- wife, the boss, the husband -- I think they hold back as long as they can. The reason is they are trying to figure out for themselves, first of all, what is going on. Since they don't know, how can they go about telling what they don't know.

Also, many of the feelings for a man might be interpreted as a weakness. For example, "Why don't you want to go to lunch with me?"; "What do you mean it makes you nervous?"; "Do I make you nervous?" You want to try to go on and function like your associates as long as you possibly can until finally it gets to the point where you know you can't hide it any longer.

INTERVIEWER: So, for the most part, agoraphobics hide what is going on inside them?

SUBJECT: Yes. Until finally they get to the point where they are exhausted and don't care any longer. Something inside them says "You've got to tell someone because you and your body can't go on any longer. You need help. Let it out. The time for hiding is over. Do what is necessary. Go to the hospital, the psychiatrist. Do whatever is necessary. You've got to let it out because the pressure is too great inside. The breaking point has been reached. By the time the agoraphobic gets to this point, he is in real trouble . . . serious

trouble.

I would assume that if the problem were better known, a lot of the taboos and fears that build up in your mind would allow the agoraphobic to seek help a lot sooner.

Remember, as I said earlier, the majority of the doctors don't know what is going on with us and they contribute to the problem by telling us, "Well, I can't find anything wrong with you."

INTERVIEWER: So, you feel lousy and are told nothing is wrong with you. And you wonder, "If I'm so healthy why do I feel so bad!"

SUBJECT: Right. In fact I used those same words earlier to a doctor who insisted there was absolutely nothing wrong with me. I said in return, "In that case, why do I feel so terrible?"

I almost feel cursed. I still have to ask myself in prayer to God himself, why I have this. I feel empathy for those who don't know what they have and don't know how to get the help they need.

INTERVIEWER: You say your wife knows? Has the agoraphobia affected the marriage or the quality of your relationship at all?

SUBJECT: It has almost destroyed it. Uh . . . My marriage right now, today, is frayed. It is shot to pieces. In the beginning, my wife was sympathetic to my problem. But after a year and a half, those feeling of sympathy turned to other feelings of "You don't understand what is wrong with you; I don't understand what is wrong with you and I'm kind of tired of seeing you lie around here. You won't take me out to a movie. You won't let friends come over. You won't take me out to eat. You won't talk to people; you don't talk to me like you used to. Our life together, our love life is diminished. You will not talk."

INTERVIEWER: How, then, did she interpret all this?

SUBJECT: She started asking questions about what was wrong with her. "It is me, isn't it?" Then, she started accusing me, "I think you are making up a lot of these problems because you are not satisfied with me."

Suddenly, more problems start piling up -- marital problems. Besides trying to handle the agoraphobia, the marriage starts falling apart. Anger crops up. Expressions of anger from. Where, before there were expressions of tenderness and sympathy, now there are expressions of anger and frustration from her.

INTERVIEWER: What form do these expressions take?

SUBJECT: For me they have been physical -- she has hit me because she was so angry. She has called me everything under the sun; painful, scarring phrases.

You have to understand. In my former self I am a luxury liner and

all of a sudden I am a sinking ship. I don't know how to stop the leaks -- I don't know how to -- and suddenly I'm getting more holes punched in me by my wife. It becomes a progressive problem. First there was the agoraphobia. Then the agoraphobia developed secondary and tertiary problems. The build up of secondary problems is incredible. I was losing my job; losing my wife; losing my mind; I thought I was losing everything.

The agoraphobia symptoms are a lot better now, but the scars left over from that battle, from the many battles . . . I don't know whether we will ever recover from that nor not. I just don't know.

My wife really got hammered. I didn't hammer her but it was the limp body on the couch for months at a time that got her . . . .

INTERVIEWER: . . . the unresponsive, non-communicative . . . .

SUBJECT: . . . the unresponsive, exhausted husband got her. And to a young woman, normal in every way that is progressing in every way, her work career . . . she is wanting to get on with life: "let's be saving for a home"; "Let's be planning for the future". I couldn't even plan the next day. Like I said, there are scars that are deep. They are still there and I don't know . . . I'm trying to sweep up the parts and pieces of my life. Those bits and pieces of my marriage have not been swept up yet. We are in a holding pattern. We have a beautiful three and a half year old son that is really the glue that keeps us together right now. I don't think if he wasn't there, we would be together now. It isn't because I don't want her, it is because when she looks at me she sees the agoraphobic part of me. She can't forget. It has been that much pain to her.

INTERVIEWER: You mentioned depression earlier . . .

SUBJECT: It is fatal. I seriously considered taking my own life. I had the whole thing planned out. I am certainly not at the same point of sadness now. But I am concerned that my depression has been communicated to my spouse. I'm scared to death my wife is now as depressed as I was a year ago. All the danger signs and phraseology of depression -- "What's the use"; "Why go on?" "Everything is going down the drain"; "I don't want to get up" "I want to kill myself"; "I hate everything" -- all these phrases are used with regularity around our house by my wife.

INTERVIEWER: Is she employed outside the home?

SUBJECT: Yes. She is a systems analyst and works in the computer field. She has an excellent job. A high-paying, stressful job.

INTERVIEWER: When you attended the Agoraphobic Recovery Workshop, did your wife accompany you?

SUBJECT: No. She did not attend because of her taking care of the baby. However, even if we did not have the baby, I still don't believe she would have attended with me. As I have already said, her feelings of

sympathy had long since turned into feelings of frustration and anger. Were she sitting here right now with us, I think she would say, "At that point in time I had already invested about all the time I was going to invest. I have invested years and now I'm on my own to find a cure. I have to get on with my life. I will still try to be there, but I can't invest the energy and time I once did."

INTERVIEWER: If you could send a message out there to people who find themselves married to agoraphobics, what would you tell them?

SUBJECT: First, I would tell them that the feelings of agoraphobia are incredibly intense and are not aimed at you or anyone else. These feelings have not been constructed for a purpose; They are happening through no intent of his or her own. These feelings should not be taken personally by you at all. As I said, these feelings are not constructed to hurt anyone in the marriage.

A lot of the spouses, after the initial sympathetic reaction wears off and they begin to get upset and frustrated, start thinking, "Hey, my husband/wife have developed a 'wounded duck' syndrome -- You know, the 'broken-wing' syndrome. They are hobbling around looking for attention. But, Hey! I need some attention, too, but I'm not getting one bit. I has become an all-give and and no-get situation. It is no longer a two-way street but a one-way street and everything is going his/her (agoraphobics) way. And I don't like that anymore. He is always talking about how bad he feels, but what about how I feel?

Well, to clear away all the smoke, tell those married to agoraphobics to remember their husband or wife is in incredible pain -- the most pain they have ever been in their life. And the other side of the family has to realize that. None of it is on purpose and any agoraphobic would gladly say, "Okay, it's all over with. I'll trade away the agoraphobia; I don't want anything to do with it anymore."

The last in the world an agoraphobic wants is to wish bad feelings off on anyone. Unfortunately, spouses take the agoraphobia personally and it gets into a personal hurt situation.

INTERVIEWER: You, then are telling the person married to an agoraphobic not to take the agoraphobic symptoms personally?

SUBJECT: Absolutely. On the other hand, just how much can you ask a person to endure? It's a terribly hard thing to ask your wife to endure something like this. You've got to realize that the person they married is not there anymore. He or she still looks the same but they've changed. They are crumbling before your very eyes. They are fighting . . . fighting for their very survival. Everything has changed. All the rules they were playing by have all of a sudden gotten mixed up.

INTERVIEWER: Agoraphobics, then, are fighting for personal survival first and marriage is second in line?

SUBJECT: That is absolutely right! At it's very worst in the middle of an anxiety attack, you feel like you are fighting for life itself.

INTERVIEWER: You and your wife have evidently talked about all this quite a bit?

SUBJECT: Oh, yeah, we've talked about it a lot. It's at the point now that we don't talk about it that much any more.

My wife has never experienced a panic attack. It's still incredible that after being married to me for eleven years and going though all the things she had gone through, she still doesn't understand the devastation, the pain and the suffering. In the back of her mind, she still questions the reality of it all -- "How much of it is dramatics and how much of it is true?"

It has caused a giant canal to be dug between us as far as trust and loyalty is concerned. It has come down to matter that she doesn't like me. Many times she tells me, "I just don't like you any more. I liked you when we got married but I don't like the person you are now." Agoraphobia has molded and shaped me into a person she doesn't like anymore.

I feel that underneath all the hurt and pain there is still a real me there; there is still an ember there. But there is a lot of scar tissue.

Understand that it is difficult for me to be a romantic, loving, caring husband. Quite honestly, I haven't had a lot of experience with those kind of feelings since we've been married. I've been married for ten years and fighting agoraphobia ever since we've been married. There hasn't been a lot of time for the role of looking out for my wife. These are hard things or me to say but they are absolutely true. Over the past couple of years, I've devoted more time to my son and my wife than I have in all the previous years. But it might be too late . . . just might be too late for us; Again, I don't know. If the marriage does fail, I'm not looking for a scapegoat, but I can honestly look to the agoraphobia and what it did to me and ultimately to my family.

INTERVIEWER: What do Agoraphobics need to hear from their spouses?

SUBJECT: I think they need to hear accurate, understandable feedback from their spouses. What I mean to say by that is we need to hear "I am familiar with the disorder; I understand it and I understand what it is capable of doing. You and I are going to team up together and get through it together. You are going to have a partner all the time for as long as you want me. I am going to help you through this. I love you and I am going to help you get through this problem." These are the words I would like to have heard . . . without a doubt. This would mean a lot.

The problem with agoraphobia is no one knows a lot about it. Not even the professionals! At least the professionals I've been in contact with. I was angry. I had concluded I would have this problem, whatever it was, until it just went away on its own or possibly for the rest of my normal life --except I don't consider this a normal life --

but as long as I live, I'm going to have this problem. This is not living, this is an endurance test. And the question is just how long can I endure this?

If things hadn't gotten better, I don't know where I would be now. It scares me to think about where I would be. On this side of death, there could not possibly be a pain worse than the agoraphobia.

The thing that really frightens me is that I've held up my shield and fought off the agoraphobic rocks thus far. But it gets so miserable on this side of the fence that death seems preferable. Finally, I got to where I was ready to risk seeing what it was like on the other side of the fence.

INTERVIEWER: . . . And this is difficult to describe to your wife or anyone else . . . .

SUBJECT: Yes, because while I was building up a shield to fight of the agoraphobia, my wife was building up a shield of her own against me. This has hurt her too. There is a lot of disappointment. She cooked and cleaned and washed and took care of me just like she took care of our infant son and I gave back nothing in return.

INTERVIEWER: So your wife was thrust into a 'giving' role for quite some time.

SUBJECT: For seven of our ten years of marriage is was so lopsided that it is awful for me just to talk about it right now. I don't know whether I will ever be able to make that up to her or not because she can't forget it. There is no way she can forget it . . . no way. I think she really tries to forget it but so far she hasn't been able to. She is very open about admitting that to me. She is scarred . . . really scarred up.

We came awfully close to just calling it quits which was an incredibly frightening thing to me because an agoraphobic gets so dependent on their spouse. "You can't leave me. You are my security blanket. I need you. God! Don't leave me, you are all I've got left!" The loss of my wife would be more than the loss of a spouse, but the loss of everything that was soothing in all that pain.

INTERVIEWER: Is there any particular "hump" you need to get over right now?

SUBJECT: There are still several humps. There is first of all the hump of agoraphobia itself. I still, occasionally, suffer the symptoms of the agoraphobia with the anxiety attacks. The memories of the past are deeply etched in my mind and I deal with the "what-ifs": What if I had never had the agoraphobia, where would I be now? In other words, "what might have been?" Also, what friends have I lost? What enemies have I made that really don't understand what is going on? What decisions have I made that resulted from the agoraphobia because I was running scared? Will I ever get over this? I don't know if it is possible or not to ever get over it. I can get around and function pretty well

compared to the way I used to be. But I still have it and still want to get over it real bad.

So I have the hump of the agoraphobia, the hump of fighting the secondary problem of depression where all I want to sit quietly and stare at the floor. So I have to fight the battle of agoraphobia, the battle of depression, plus the battle of keeping my marriage together. I am putting am more energy into my marriage than I have since we've been married. I've been doing this for the last year. I can honestly look back and see that I am devoting more time and energy to keeping this marriage together, because I want us to stay together, both for my son, my wife and myself. I don't want to give up all the things we've worked together for. She is willing to give it up right now. Were I not showing some effort, our marriage would be history right now.

INTERVIEWER: What are some of the particular efforts that seem to be working for you in salvaging the marriage?

SUBJECT: It goes without saying that what I'm doing now is no magical thing. I'm devoting the time to my wife . . . . I'm just talking about the conscious effort of listening; I'm listening to her; asking her what kind of day she has had, how she feels. I'm asking her what she wants for Christmas. I'm taking our son to the playground. I am taking the time to do the things agoraphobia took from me.

The image of the agoraphobic is one of a self-centered individual who is doing all this to draw attention to himself -- I've been told this by professional people: "You have dreamed all this just to get attention." A spouse often reaches this same conclusion -- "You are doing this on purpose."

What seems to be keeping us from splitting any further is that I am obviously giving more time to our child; I am obviously giving more time to my wife. All the way across the board from making the bed in the morning to cleaning up the dishes at night to helping around the house to realizing that she works just as hard as I do every day; her problems are certainly just as big as mine. She needs my love and support just as much as I need hers.

INTERVIEWER: Now that you are getting a handle on the agoraphobia, you have time and energy to work on your marriage?

SUBJECT: Right. However, a major concern is that after she has lived with my agoraphobia for ten years now, she is starting to reflect me. I am now seeing the female counterpart to my agoraphobia -- now she is becoming hesitant to go out; she is the one that has lack of energy; she is the one that can't communicate clearly. There seems to be a turn of the table. This hurts me to think I was the cause, if in fact I was, of her present depression.

This is a very sore spot between us. She is blaming me for her problems by saying, "I'm sorry, but all that I went through when you were sick is now spilling out." There is a lot of instability right now between us. I don't know how this will work out. It worries me.

INTERVIEWER: Any social limitations today?

SUBJECT: I still have difficulty in getting out sometimes. One of the problems I have is for me to cull the true feelings from the agoraphobic feelings. The non-agoraphobic person will have times when they feel "I just don't want to go to the show this evening. I've had a hard day. I'm tired. I just really don't want to get out this evening."

An agoraphobic person has been conditioned to not want to get out because of fear of an anxiety attack. If he gets pretty much over his agoraphobia; he comes home after a hard day, doesn't really want to get out and go to a movie. For the recovering agoraphobic, it's difficult to know whether its the agoraphobia talking to you or a normal, natural reticence to go to a movie, preferring to stay home.

INTERVIEWER: In listening to you, I'm impressed with just how hard you have worked and how far you have come. You seem to have made quantum leaps of progress. I'm not saying it feels like you have made a lot of progress, but it from where I sit, you have come a long way down the pike. Any particular coping mechanisms that seemed to have worked for you towards recovery?

SUBJECT: There is no question what has helped me to live through it. I was one of the fortunate ones who found out what was wrong with them. After having the agoraphobia for four years I found out what it was. Finding out what it is, finding out it has a name, finding out there are a whole bunch of other people who have it, talking to people who are afflicted with it, hearing other people talk about the suffering they are enduring -- the same suffering you are enduring. In order to survive it you say to yourself that all these other people are enduring it so you can, too. Understanding the physical changes in your body when a panic attack hits. All these things help you to get through it. All of a sudden there is a reason for what is going on. The agoraphobic is desperately seeking reasons. He seeks all the information he can lay his hands on to understand what has happened to him.

INTERVIEWER: So, the educational component is vital to recovery? Being able to give it a name and know what is going on inside your body is crucial to the recovering agoraphobic?

SUBJECT: This helps you realize you are not going crazy. I knew I was sick but no one could tell me what was wrong. I was told, "You are just nervous. Here, take these tranquilizers."

Fortunately, however, I was one of the lucky ones. I bungled my way into a relaxation, biofeedback clinic in 1977. I still did not know what was wrong with me. The first biofeedback equipment had just been introduced into our city and I knew I could not continue with the high level stress and tension in my body. The female therapist asked me if I knew what was wrong with me and I told her I was just nervous. She informed me there was a name for my problem -- agoraphobia. That word meant absolutely nothing to me. Then she put me onto a book about agoraphobics.

The very reason I was so far beyond all the others in the Agoraphobia Recovery Class was because of this very reason -- I was informed. I knew what was wrong with me and was on the road to learning how to relax. I would drive myself to the class and the other people could not believe that I actually drove myself around. Not only could I drive but I managed to keep my job. The others stood amazed that I could drive and continue to work with agoraphobia. Some of the other people in the class accused me of faking it and that I wasn't really agoraphobic. "You must not have it. Or you must not have it very bad. Your's must be a very mild case." Those people who could not go to the mailbox, before they go to know me, wanted to know why I was in the class to begin with. The only reason I was so far along at that point was because someone had told me what was wrong with me and pointed me in the direction of information.

INTERVIEWER: Is being able to identify the name of the beast (i.e. agoraphobia) really all that important?

SUBJECT: Well, you sure can't find out what is wrong in emergency rooms. You can't find it from you general practitioner and chances are an older, established psychiatric practitioner will not be able to give you any information either. Your only help comes from phobia clinics and those people who have their ear to the ground.

You've got to understand, what is the person in Marshal, Texas who has built porches all his life or put roofs on houses. All of a sudden, he cannot get in his truck anymore and go to work. He probably doesn't know what 'phobia' means because it is not part of his thinking or his life. There has been no reason for him to know. The only thing he knows is that something is terribly wrong and he needs help. This very person called me late last evening from the Emergency Room in Marshall, Texas. He had seen my name and phone number listed in an agoraphobic bulletin as recovering from agoraphobia and willing to talk to other agoraphobics. He has been house-bound for a year and has six children. His wife has taken a job in little gift shop and brings home $100 a week. He has become totally incapacitated and resorted to alcohol to reduce the pain. He wept over the phone. He had never before talked to a man with agoraphobia.

INTERVIEWER: Have you ever felt the need to talk to someone about what was rummaging around on your insides?

SUBJECT: All the time! Number one, I enjoy talking to people and I sometimes think I talk too much. But I analyze that as perhaps trying to make up for all the lost time of those years when I did not talk to anyone. People looked at me and said I wasn't a very friendly person. "He doesn't say anything...He's just not very friendly. He's an introvert." After people ask you to lunch three or four times and you turn them down repeatedly, they conclude, why bother with him anymore. Or other couples invite my wife and I to the movie several times and after repeated "My husband is not feeling well this evening...My husband not feeling well this evening...My husband is not feeling well this evening" Finally, they just give up.

So, I am feeling a need to just talk to people now. But also, I'm not over the agoraphobia and feel the need to talk to people about what is going on with me. It is good to know you have someone who is willing to listen.

INTERVIEWER: But you said agoraphobics tend to hide it. What are they afraid of?

SUBJECT: There is a taboo in our society. Just mention the terrible disease Cancer and you get their attention and the reaction, "Oh, NO!" Well, mention a mental disorder or "Have you heard about (subject's name)? He has a mental disorder." This doesn't get the same reaction the Cancer did. It results in an "Uh, Oh! We'd better stay away from him," or "Hmmm. The guy went crazy, did he?" or "Guess we had better stay away from him." Suddenly you are stereotyped into some kind of 'nut'. He's unstable. He's a wierdo: "Can you believe it, the guy cannot even stand to go to lunch with me." Having some problems in your head is the wrong thing to be admitting to...the wrong thing to be admitting to. Admit to appendicitis and the reaction is "Oh my God! Get him to the hospital!" The pain in your side is accepted very quickly. But go to the hospital and tell them, "I keep having these spells where I become anxious and cannot go to work." The reaction has been, "What do you mean you can't go to work! Grab a hold of yourself!

INTERVIEWER: You mean that you have heard these statements before?

SUBJECT: Many times. And others: "You are not grown up yet. We thought you were an adult;" "Accept some responsibility;" "Be a man...Stop crying in your beer and act like a man;" "You should've gone to the service. That would've straightened you out." They hit you with all kinds of things.

Then your wife hits you with, "Why in hell did I marry a weakling like you!" Boy, that hurts. Sort of the icing on the cake.

Then of course, the overwhelming fears are job-related problems. You have a mortgage, a car payment and family responsibilities. And of course these responsibilities are being met by your job. The fear of losing your job works in harmony with the fear attack. Oh, they work well in harmony with each other.

INTERVIEWER: However, you did confide in your employer and lay all your cards on the table, did you not?

SUBJECT: Yes. And going into his office and admitting all these things, knowing I would be terminated from the firm. But that day the agoraphobia was so bad that I had accepted the loss of everything. It would have been no different, I can imagine, just walking down the corridors to the gas chamber.

INTERVIEWER: ...it was the end of everything for you...

SUBJECT: ...the end of my job. The end of my nice home. The end of my

marriage. The end of my nice car. All was gone.

INTERVIEWER: And his reaction?

SUBJECT: Instead of reacting with "Well, we're going to have to replace you" he said, "Shut the door and let's talk about this problem for a while. What is the name of your problem? Where can you get help?"

What brought this to a head at that time was our agency had just picket up an account and would entail our flying up to their corporate headquarters. I just knew they were going to ask me to fly up there and I have this deathly fear of flying and there was absolutely no way I could fly...no way.

I shared with him all my fears: flying and even driving to work. It stunned him. He promised me that he would not make me do anything that I didn't want to do. If I did not want to fly, then there would be no flying.

INTERVIEWER: This must have been good news!

SUBJECT: I couldn't hardly believe it. I had already abstractly prepared myself for the worse and instead of his saying what I thought he would say, he supported me. Then, he said something that I will never forget. He said, "I'm hurt that you've assumed I would fire you. In coming to that conclusion you have put me on a tyranical level and I'm not that kind of a guy. I'm not going to fire you, I'm going to help you." He was the one who told me about you and the Agoraphobic Recovery class and even paid the $700 for me to attend because I didn't have the money.

What can you say to somebody like that who not only tries understand the pain but is willing to help.

INTERVIEWER: What is your relationship with him now?

SUBJECT: He was promoted to President of the Agency and became even harder for me to get to when I needed him. He was sort of my security blanket. Another young man came in who was an aggressive, hard-pusher. Again, I was quick to assume, that this guy doesn't have any time for me and my agoraphobic problems. I left that firm. In looking back on that decision twenty--four months later I can see where agoraphobia probably pushed me into a decision I probably shouldn't have made. When I weigh everything now, I can see I should never have left that job. But here again, I was doing to my new boss, the same thing I had done to my previous boss -- making decisions for him that he had not even made. Agoraphobia was pushing me into that.

INTERVIEWER: You were conjuring up all sorts of images?

SUBJECT: Right. Agoraphobia is a real image-maker. It works your imagination overtime. It not only shows you the bad side but convinces you that it is going to happen. And it still does that to me. I still have my good days and bad days.

INTERVIEWER: Where are you now with regards to the flying?

SUBJECT: I still don't like to fly. My wife and I flew to Nassau last July. I didn't have any trouble getting there and back but I had a terrible month after that -- anxiety attacks, for no reason at all and some of the old problems coming back.

So, I still have ground to be covered. But I'm thankful for the ground I've got and hope to God I don't lose it. This possibility scares me. I have a horribly deep respect for the agoraphobia. It would be like putting your hand in a fire and experiencing severe, severe burns. Even after the healing, you sure don't want to get near that fire.

INTERVIEWER: It's just a tough memory to shake, isn't it?

SUBJECT: Yes, it really is. Agoraphobia has done some awful things to me. It has caused me to lie. It has caused me to question myself. I has almost broken up my marriage. It has made me an extremely skeptical person. Especially when people say, "I had agoraphobia but today, I'm cured. I haven't been bothered in five years." I'm skeptical of comments like that because I've had it ten years and I still have it. And I consider myself one of the fortunate ones who've received a lot focused help directly aimed at agoraphobic problems. And I've still got it. I've put more effort and money into it than perhaps the average person may have the willingness or the means. And I've still got it. I still ask when I'm going to get over it. I ask myself how much more damage it is going to do. It is certainly capable.

INTERVIEWER: But it does sound like you are in control?

SUBJECT: Yes. I am more in control that I ever have been. This is not to say that occasionally I don't let it have it's way. I poke fun at it as much as I can. What I mean by this is I consciously place myself in situations where an anxiety attack could easily happen with potentially hazardous results. For example, I get myself away from any support at all. I get away from home in places where I'm not familiar with the territory and I am on a motorcycle. I rode motorcycles a lot before the agoraphobia but I was afraid I would lose control of myself. Now I go on rides regularly. I ride territory I'm not familiar with. There is no way back home. I don't know where safety is. I don't know where the next phone is. Last Saturday, I rode 100 miles. You have to be in a pretty good state to throw you leg over that motorcycle. Then, too, I season the setting with a lot of friends who don't know anything about agoraphobia where if I did have an attack, I would have to bear the embarrassment of having to explain to them what is going on. So I concoct a scenario of disaster: On a motorcycle, surrounded by people who know nothing about agoraphobia, riding in places where no help exists. I do this because I have to prove to myself that I can. This is why I went to Nassau. I had many anxiety attacks but my wife came in one night and said "We are going to Nassau! And we are going with (friend's names) who have no idea of your problem." It was a set up for a lot of anxiety attacks. It was an agoraphobic nightmare. I had never

flown. But I did it and lived through it. One day on the beach I thought, "here I am on a island. What would I do if I needed to get off the island? What if I had a heart attack?" Here was the old agoraphobia trying to inject the fear thoughts into the situation.

INTERVIEWER: How did you fight that particular battle?
SUBJECT: Learning how to relax is the fuel to fight agoraphobia. Relaxation frees up time that was spent in fighting agoraphobia for the normal functions of life. Otherwise all your time and energies are directed to fending off the agoraphobia.

Subject: Non-agoraphobic Wife -- Age 33

INTERVIEWER: How long have you, and (husband's name) been married?

SUBJECT: Ten years.

INTERVIEWER: Did you know about the agoraphobia when you married?

SUBJECT: While he was still in college he had no problems at all. He did well in school, and was fatter than now . . . he had no problems at all. Upon graduating from college, and wondering what to do, he moved in with his folks. Both his mother, and stepfather are strong, domineering personalities, and my husband is one who likes harmony.

INTERVIEWER: A peacemaker?

SUBJECT: Yes. Also, since the Seventh grade, his mother, and stepfather day after day told him how stupid he was and everything he did was no good. After college he moved back in with them and went into business with his step father. That didn't work out so they sold the business and he moved from Missouri to Tulsa. Going home on weekends was when he began having trouble. He would get onto the turnpike and about fall apart and think he couldn't drive on the turnpike. We were dating at that time and I would drive to Tulsa to see him. He would not want to go out to a show or anything.

SUBJECT: What did you think was going on when the guy you are going with cannot even go out to eat?

INTERVIEWER: I had been around a lot of people in my life who were nervous.
Mother had a nervous breakdown and one of her sisters did also. And my grandmother is a nervous person. So I identified it as his just being nervous. Unfortunately, I have very little toleration for that because I saw my mother, my aunt, and grandmother as 'weak'. When I was young and my mother or aunt had problems, I thought, "This is ridiculous! I'm never going to be like that." So when anyone is nervous, I hear a little man in the back of my brain say, "This person is a weakling" because I see it as a sign of weakness.

INTERVIEWER: And you still view illness as a sign of weakness?

SUBJECT: Yes.

INTERVIEWER: Are you than making an exception for your husband?

SUBJECT: Yes. I have pretty much decided that we are going to stay married. But I had doubts for a few years. Also, we have a baby and we want a stable family environment for him. Both of us came from divorced home. We don't want that for him.

INTERVIEWER: When did it begin to create problems for your marriage?

SUBJECT: Usually, (husband's name) is very outgoing and into all sorts of hobbies -- radio controlled planes, and cars, motorcycles. But he started going through periods where he would do nothing but lie on the sofa. He would go to work in the morning and come home and lie on the sofa -- Work all week and lie on sofa all weekend. After a while this would ease off and he would get back to his old self. I thought he was just lazy.

I asked him what was wrong and he kept telling me it was his supervisor at work who would get him down. This got me so upset because I'm the kind of person who does not take anything from anybody. I just could not understand (husband's name) letting this guy at work run over him. For 5 years I kept telling (husband's name) to tell this guy to "take a hike;" just one time tell the guy off.

During this time we had trouble with his mother. We wanted to buy a house and she would horn her way in and come to town and tell (husband's name) what to do. When she got here, she kept telling (husband's name), "Why, you can't do that until (stepfather) gets here to help you out." I kept telling my husband, "All you have to do is tell her to 'take a hike'." But he would not do it.

After five years of this, he started really getting sick. In 1979 things got really bad. He realized he needed to do something about it because he was getting so nervous from it -- he didn't want to be in a plane, didn't want to be in a crowd; he didn't want to drive on the turnpike.

INTERVIEWER: What did he decide to do about his nervousness?

SUBJECT: He started going to doctors. First he went to our family doctor. He was the best because he would sit and let my husband just talk for an hour. Then, he referred (husband's name) to the Psychiatric Clinic. Well, he went down there and was assigned to a psychiatrist who simply prescribed drugs. For a period thereafter, he went to several M.D's who simply prescribed tranquilizers or antidepressants. Every time he would come home with these prescriptions, I would talk him out of taking all the medication because I knew they weren't sure what was wrong with (husband's name).

The best thing that happened to him at that time was going to a medical center for training in biofeedback to relax. During this time in 1980 we heard the word 'agoraphobia' for the first time. (Husband's name) told this to the M.D's and they were totally divorced from any knowledge about it whatsoever. They still wanted to prescribe tranquilizers for my husband.

INTERVIEWER: So the physicians had little or no knowledge of the agoraphobia?

SUBJECT: Right. So (husband's name) found a couple of books and

started figuring out for himself what was wrong. By this time I was out of patience. I had run out of gas a long time ago and had no toleration of it and his lying around on the couch. At this time we had a baby and there was so much for me to do and it seemed like the whole time all he was wrapped up in was what was wrong with him. I couldn't have anything wrong with me because there was no time.

(Husband's name), at this time, started going to another psychologist who diagnosed severe depression and seemed to really help him. But he had to stop going to him because the cost was so high. We have spent thousands of dollars on this thing with drugs and doctors -- Four thousand dollars alone on psychologists, and psychiatrists.

INTERVIEWER: You husband did not know what was wrong with him, the professionals did not seem to know either. What did you think was wrong with him?

SUBJECT: I'm real short-fused and I thought he just needed to 'snap out of it'. I ran out of gas. I feel like for the first five years, I was nothing but understanding and reinforcing. I felt like I was in the marriage all alone because he was all wrapped up in his problems and I'm left alone. So I figured I might as well build something for myself because I did not have a partner; He was too messed up to do anything. And yet I knew he was a normal guy.

It wasn't until the Seminar on Agoraphobia that things started changing. (Husband's name) would come home from the sessions and tell me about some of the people who couldn't go up an elevator. I was still suspicious about all this because I just cannot relate to someone who, for example, cannot go up an elevator. I thought "This is just a bunch of nonsense."

INTERVIEWER: When was the turning point in your husband's agoraphobia?

SUBJECT: This may seem insignificant to you but I feel the turning point was in 1981. His folks came to visit us in our new house. He and his stepfather were out in the yard looking at the house, particularly the roof. His stepfather said, "I wouldn't have bought this god-damned house, if it was me, the shingles are falling off the roof!" (Husband's name) looked at him and said, "Look, you did not buy this house. I did, so why don't you just shut up!" I nearly fainted. His stepfather nearly fainted but backed off and got a smile on his face and never said another word about it. This seems so insignificant but it was the turning point.

Since then, he has continued going to the psychologist and learning to become more assertive. His mother would call and try to manipulate him by instilling guilt but now he has started speaking up to her.

INTERVIEWER: So you feel he is making progress?

SUBJECT: Oh, yeah.

INTERVIEWER: What is it like to be married to an agoraphobic?

SUBJECT: Sometimes I feel I have to do all the work while he is all hung up on himself. I thought for a long time that he was self-centered, selfish. He is getting better. Before, he wouldn't help or participate in anything and he would give the excuse that he was nervous, didn't feel like it or couldn't handle the situation. I thought it was a bunch of nonsense. Because when I had the baby and I would go home not feeling well, that was just tough! I still had to do everything. I did not get any help from him at all because he was giving excuses about how tired he was. Along in here somewhere, he started having chest pains. He checked it out with my cardiologist who said there was nothing wrong with him but tension.

INTERVIEWER: When were things the worst for you and (husband's name)?

SUBJECT: When I first started traveling out of town on my job before the baby was born. Whew! This was the low point in our marriage. He was having a really rough time with the agoraphobia and was shaky and nervous. I got to the point where I could not stand it anymore. I was so looking forward to getting out of this town for a whole week -- A Hewlett Packard User's meeting on the West Coast. Hey. He broke down and cried the night before I was to go and asked me not to go. I wasn't about to cancel this trip. What does he do but call up his mother (in Missouri) and ask her to come down and stay with him while I'm gone so he won't be alone. I thought, 'This guy is a nut! Thirty years old and going to have mommy come down and stay with him. He's a basket case. I've got to get out of this mess!' This was in 1980. He took me to the airport the next morning. He was such a mess, I just got out of the car and left. I got on the plane and was real upset the entire flight.

I would call back and see how he was. He seemed to be doing fine but I resented like the devil his mother babysitting my house -- she even wall papered part of the house while I was gone. Good grief! It was my house and (husband's name) just let her do it.

When I returned from San Francisco, he was on a high and said he was real sorry about the way he acted and wanted to make up. At this point, I wasn't for sure whether I wanted to participate in this any more or not. This was a real low point.

Another time when I had to leave town on business, we had the baby and rather than take care of the baby himself, he hired a lady from Grandmother's, Inc. to help out. This was unnecessary as we already had a babysitter. He just didn't think he could handle it.

Still, he doesn't like my leaving town on business but he is getting better about it. He is becoming more self reliant -- which he wasn't at all -- and he is more confident.

INTERVIEWER: What must this do to a wife's respect for her husband?

SUBJECT: I have on occasion thought he was a wimp.

INTERVIEWER: What about right now? Is he a wimp now?

SUBJECT: No. I don't think so. You see, he is the one who does all the dealing when we buy a house. He is real smart. He goes to work and now stands up for himself. There is no problem any more in his standing up for himself.

INTERVIEWER: So you feel better about him now?

SUBJECT: Yes, a lot. About three years ago it was really bad. But I think he is making a lot of progress. The Agoraphobia Seminar has helped him a lot. Another thing that has made a difference is the people (agoraphobics) who call him for help. He will be on the phone for three hours at a time. It's incredible some of the stories they have to tell.

He's doing much better. Before he was really angry -- frustrated with himself and the low self-esteem -- plus for a long time he did not know what was wrong with him. He couldn't put a label on it.

INTERVIEWER: What is the state of the marriage right now?

SUBJECT: I think we both realize we are going to stick together. Although, he is not real demonstrative.

INTERVIEWER: What has the agoraphobia done to your husband. You knew him before all this happened and you have lived with him during it all, so you probably have a pretty good picture of (husband's name).

SUBJECT: Before, he was a real, happy-go-lucky. He made good grades in college. He was really self-reliant, good self-esteem, and responsible.

And now, no self-esteem; not at all self-reliant; Nervous; No appetite. Just really pathetic. Totally dependent on input from other people. No confidence.

INTERVIEWER: If agoraphobia does that to a person, what must it do to a marriage?

SUBJECT: It has definitely made us grow further apart because of my running out of patience listening to all this. I'm probably a bit more understanding now because I understand what is going on. But for the first five years I did all the giving and then I decided he was all wrapped up in himself, so I've just grown further away. When he will not participate in things with the baby and me, we just go on without him. We are going to have to really work to do things together. We are going to have to sit down and make a plan about what we are going to do as a family. I got to where if I wanted to do something, I would just go ahead and let him lie on the couch. And I am still that way. But he is coming out of that now. But we are going to have to come up with a plan to do things as a family.

INTERVIEWER: What might some of those things be that you would like to do together as a family?

SUBJECT: Go canoeing, take a vacations and go to the park. We have a good time when we do things like that. We did go to the Bahamas last summer but he was a pain. He went to the doctor and he gave him Transene and Valium to get him through it. We haven't been able to do things like this before -- fly places together.

INTERVIEWER: Sounds as though he has come a long way?

SUBJECT: That's right. He even gets mad at me now. I'm a real hot-head but he screams right back. That's okay, though. I don't want somebody I can run over. I want someone who can speak up for himself.

INTERVIEWER: Any message for people who are about to marry an agoraphobic person?

SUBJECT: I would probably tell them to wait. Wait until they either get over it or until they show they can hold a job. Wait until they have been through a couple years counselling. All the marriage will do is add pressure. I just wouldn't do it. I would tell them not to do it.

There was a point when he was so messed up and our office was involved in a big project. I remember days I would just sit in my office and stare out the window. I would call him up on the phone and tell him I simply had to go out of town on business and he would just get crazy. I thought then I would just have to get a divorce. This was August of 1980.

INTERVIEWER: Who all knows about your husband's agoraphobia?

SUBJECT: He may have told his parents but I don't know. He did tell his mother he was seeing a psychiatrist but that has been of recent. I don't know if he has told her about the agoraphobia or not. A couple of friends know he tends to be nervous and has stomach problems. He did tell a close friend of his back home who is an M.D. that he had agoraphobia but the doctor-friend did not know what he was talking about.

INTERVIEWER: Ever had to make an excuse for him?

SUBJECT: Yes, and I don't like that at all.

INTERVIEWER: What do you need from your husband right now?

SUBJECT: More participation in what is going on in the family. If I'm going to have to work, we need more of a fair relationship at home. He is doing much better now.

INTERVIEWER: So you feel you have been carrying both loads in the family. Not only your load but his also.

SUBJECT: Yes. Yes. And I really resent -- I'm going to have to get over this resentment -- the first two years after the baby was born.

Hey! I about went crazy. I was getting up at all hours of the night and he, not once, got up with the child in the night. I was working full time, getting up twice in the night with the baby, getting up at 5:30 A.M. to get ready for work, taking the baby to the babysitter, working all day long, picking up baby from the babysitter, coming home and taking care of the baby. I didn't have any time for myself at all for two years.

INTERVIEWER: And where was he during all this?

SUBJECT: He was all wrapped up in himself and his problem. I got a fill of it and was mad. I ended up going to see a psychologist; I thought I was going crazy. I only went twice because he said I was fine. During all this I built up a lot of resentment when he would not help me. And I resent him now when he will not participate . . . like on Saturday morning. Not once has he ever said, "Hey, let me get up and fix breakfast and take care of the baby while you stay in bed." I need for him to participate with the baby more. But he is doing better. I still feel that if he would take up strenuous exercise and get physically fit that a lot of this nervousness nonsense will go away.

Sometimes I get real mad on the weekends. I'm doing laundry and he is lying around. And I think, "Gee, it would be nice to lay around" but here I am folding clothes, doing laundry, and getting ready for the week." He doesn't do anything to help. It's getting better because I can now get away on some weekends and go shopping with my friends while he takes care of the baby.

Yet, I'm real critical of him -- probably too much -- because I still have a lot of resentment left over from the past 10 years. If I end up doing all the laundry on a weekend while he sits around, I get mad. And I speak right up, too.

INTERVIEWER: When you say that you speak right up . . . .

SUBJECT: I yell!

INTERVIEWER: Every say any hurtful things?

SUBJECT: Oh, Yes. He's getting thicker skinned and also he's talking back, which he never used to.

INTERVIEWER: What about your intimate relationship with your husband?

SUBJECT: The only problem we have is that I want to play. I'm playful. I had a brother and I want to wrestle around. We can't do that. He is not that way at all. I want some hugs and contact other than just in bed. He's not that way. He is not playful before or he's not playful anytime. He doesn't play with the baby. He doesn't wrestle around or rough him up like dads do. He doesn't hug the baby. I stop and tell him "You need to hug the baby . . . hug him up and tell him you love him." And he will do it. He is getting better at that, too, but he is just not real forward with it at all.

INTERVIEWER: Do you and your husband ever sit down and talk like we are doing right now?

SUBJECT: No. We have talks. We always eat together after work and talk about what went on at work.

INTERVIEWER: That's good. But ever have talks that aren't about work but about yourselves and how you are doing . . . intimate conversation?

SUBJECT: No. I don't ask him that kind of stuff -- "how are you feeling?" -- because I know I will always get a negative answer. If I have had a horrible day at the office, I leave that at the office; He brings it home. And I don't ask him how he's feeling because I know it will be negative. There have been a lot of times when I was feeling awful, head cold or whatever, and would like to turn to somebody and say, "I feel terrible. I'm going to go in the bedroom and go to bed." But I never do that, because I can't.

INTERVIEWER: . . . Because you have to be the strong one?

SUBJECT: That's right. Typically, the other day we were talking about how terrible it would be if something happened to the baby. He just said, "Well, you would just have to get me through that." I got to thinking, "Well, crum! Who's going to get me through that?" I feel like I have no one.

I'm getting more tolerant. He doesn't have as many complaints as he used to. I've had it up to here. I finally realized one day that for the first five years of our marriage all I heard was "What was wrong with your husband."
But, no we don't talk like this because I don't want to hear all the negative stuff.

INTERVIEWER: Well, you appear to have weathered the problem pretty well.

SUBJECT: I'm a survivor. My grandmother says I have the survivor instinct.

The interesting thing is that my other grandmother probably had agoraphobia. She would not go on vacations with my grandfather. He would take her to town to go shopping and she would refuse to get out of the truck. Everybody thought she was a fruit loop. One day she went to the kitchen and started shaking -- she was having an anxiety attack. No one knew what was wrong with her because she would just stay in her little house out in the country, not wanting any visitors or to go anywhere. She is 75 years old and has had this all her life.

APPENDIX I

INTERVIEW VERBATIM: FAMILY D

Subject: Agoraphobic Wife -- Age 32

INTERVIEWER: I don't know anything about you . . . .

SUBJECT: Well . . . I'm married. This is my second marriage. He has custody of his two children and I have one son, eight years of age. I first married in 1971 and we separated in 1976. I remarried in 1982. My present husband is a retired fireman and I am a receptionist for a Pediatric Opthamologist.

INTERVIEWER: When did your difficulties with the agoraphobia begin?

SUBJECT: I can remember Christmas of 1976, six months after my first husband and I separated that I had my first panic attack while sitting on the porch. I had just returned from going to court about the divorce and found out that I was going to have to sell the house. Also, I found out out that same day the man who raised me was dying of cancer.

It first began with a queasy feeling and I went back into the house to be with several friends I had over. I'm not a drinker or anything like that, but I was upset over the separation and some other problems so my friends handed me a drink and a joint of marijuana and told me to loosen up. That was the first time with marijuana. I soon began to feel lightheaded and then felt like I was going to die. I was screaming bloody murder, "Take me to the hospital!"

My girlfriend lay me down and put washcloths on my head and face but did not think it was serious enough to take me to the hospital. She did not think anything was wrong.

INTERVIEWER: But you knew something was wrong?

SUBJECT: Two days later I had another attack, then another and another. Finally, I got rid of my house and moved in with my mother and lived there with her for two or three years.

INTERVIEWER: While there, with your mother, did you get out or were you housebound?

SUBJECT: I spent my time staying in the house. Occasionally, my mother and I would go to the Pancake House to eat, but no where else! I really haven't been by myself since.

INTERVIEWER: Your not being alone, does it have anything to do with the agoraphobia?

SUBJECT: Well, you don't want to be alone because you can't breathe and

you think you are going to die and there will be nobody to help you. However, when I am having a panic attack, I want to be by myself. I don't want anyone to see me. I know this must sound strange to you. I know nothing is really wrong with me . . . physically. I know I'm not going to die with a heart attack.

INTERVIEWER: What did you think was happening to you when you began having all these frightening feelings?

SUBJECT: I felt dizzy and my heart was going crazy. The room was spinning and I thought I was going to die. All I wanted to do was go back and be with my little boy. Later at a New Year's Eve party, I had a panic attack and before going to the emergency room, I needed to go and see that my little boy was all right.

INTERVIEWER: The Emergency Room? How many times have you been to emergency rooms?

SUBJECT: I have been to doctors and emergency rooms so many times it is unbelievable. I wish I had all the money I've spent on doctors and emergency rooms.

INTERVIEWER: How much would you estimate the agoraphobia has cost you to date?

SUBJECT: From 1977 until now, I've spent over $20,000 on psychiatrists, doctors, emergency rooms, and prescriptions. Twenty thousand easy. I have spent entire weeks in the hospital with this.

INTERVIEWER: What did they tell you was wrong with you?

SUBJECT: They said nothing was wrong with me. I remember at one hospital, I told them I was feeling dizzy and they told me I was just a dizzy blonde with brown hair and that nothing was wrong with me. They were joking and I was hurting. But I kept going back so many times that we got to know each other on a first name basis. I was going every other night to the emergency room . . . and at $70 a whack . . . . I didn't know what was wrong with me.

I went to a psychiatrist and he said I didn't need to see him but needed a social worker. I was seeing the social worker and telling him I was afraid to drive, afraid of this, and afraid of that. He said I was simply having difficulty adjusting to my divorce. I kept telling him, "No! This is not what is wrong with me."

Then they told me, "Take these (Valium) and you will feel better. Finally, I got addicted to Valium. The doctor switched me to Transene and I've been on it ever since. Now, I've become very conscious about my body and taking any medication.

INTERVIEWER: You mentioned your little boy . . . .

SUBJECT: Actually, I do more things with him that I would not do with anyone else. I don't want him to see me the way I really am. I go into

his room and preach to him, "Don't be scared." Unknowingly, I guess part of me has rubbed off on him because he is a little agoraphobic. He is too cautious, afraid he will hurt himself. I'm encouraging him to get out and do things. When he falls, I tell him to get up and go on. You see, I never experienced a lot of things because my mom was really protective . . . and still does.

My son is so conscious of being hurt that he is eight years old and cannot ride a bike because he's scared he'll fall. We've lived with my mother and all she tells him is, "You can't do that. You can't do that." Mom still tries to protect him and to "tuck me in."

INTERVIEWER: How is it she has all this influence on you and your son?

SUBJECT: We live on the same block. And we work in the same office. I know I can't go on like this so we bought another house about six miles from her and she has done nothing but cry since. All I can do now is call her and see how she is doing. I can't get around her because she will make me feel guilty.

INTERVIEWER: Who all knows about this agoraphobia problem?

SUBJECT: My husband knows.

INTERVIEWER: Did your first husband know?

SUBJECT: No! I am too afraid to tell him. I was always afraid that if he found out . . . .

The first two years I couldn't keep a job. I would go to work, get scared, and leave the desk. I know this was not right for the people I worked for but I couldn't help it. They would ask me what was wrong with me and all I could say was, "I don't know. I feel funny." This man was real nice and would ask me to come back. He was an attorney and I would have to go file cases for him and about half way between his office and the court house, I would get that feeling and have to step into a building saying to myself, "What do I do? I can't breathe." And I did not want to tell anybody.

INTERVIEWER: What do you mean, "You didn't want to tell anybody"?

SUBJECT: I would rather die before I would tell somebody I was having a panic attack. Well, I work for a doctor and he is on the tenth floor. When I would have to go down, say to the third floor, I would have to call my father who lives twenty miles away and have him to come and meet me there because I was afraid to go down by myself.

Things like that, which I can do now but I couldn't then. I can do more than I could three years ago but not as much as if I were normal . . . like I would like to be. I envy other women . . . women sitting at McDonald's with their kids and I envy them. I have yet to take my little boy to a park or a movie by ourselves. I don't like that. I feel like I'm cheating him.

INTERVIEWER: What if another adult went with you to the park or where ever? Could you go then?

SUBJECT: I don't know what the difference is, but if you went to the park with me and my son I would feel real secure because you are there in case something happens to me. Yet I know that if something was going to happen to me, you couldn't stop it. Nobody could. But I can't get this in my mind.

INTERVIEWER: How, then, do you function on your job?

SUBJECT: I'm a receptionist. I'm really nervous but I'm pretty good because I am nervous. I get down and play with the children. The kids like it and the parents like it but they don't know I'm really scared.

INTERVIEWER: Does your employer, the doctor, know?

SUBJECT: No. And, uh . . . my mom knows I have problems but not that I have agoraphobia. I'm too afraid to let her know that I'm seeing a psychologist who specializes in agoraphobia because she would criticize it so much that I would feel guilty and quit. I usually do what she says but this year things are going to turn around . . . . I'm 32 years old! This week-end when she got all teary-eyed that I'm moving away from her, I began wondering that maybe I haven't been the agoraphobic . . . maybe she is. But I've been made to feel guilty by her.

INTERVIEWER: Boy! Sounds as though you are really getting a handle on things and taking some control over your life.

SUBJECT: I wish I wasn't married. He is a lot nicer than my first husband, but he drinks and is an alcoholic.

INTERVIEWER: Does your husband know about the Agoraphobia?

SUBJECT: He didn't when we got married me. He found out because when we were going out to eat, I would start crying and he kept asking, "What is wrong with you!" All I could say was that I didn't know.

INTERVIEWER: How did you find out you had agoraphobia?

SUBJECT: One day I was setting at my desk and came across an article in the newspaper that described what I was feeling. I called the telephone number and later asked my husband if he would go with me to see the psychologist. He said, "Sure! And we will find out what is going on." He went with me at first and was real excited but the more independent I got, he ridiculed me, calling me a "a psychiatrist's dream." He stopped going with me and quit giving me money to pay the psychologist. Now I'm doing it by myself.

I've been taking his verbal abuse and I feel now that it is not me but that I've married someone that is as dependent as my mother. They are both really good people but they're more insecure and need me more than I need them. I haven't seen that until just now.

INTERVIEWER: And his reaction now is what?

SUBJECT: He ridicules me and says nasty things like, "You can't even go to the story by yourself" and "If you left me, you couldn't take care of (son's name)."

INTERVIEWER: What has the agoraphobia done to you? What kind of toll has it taken?

SUBJECT: Before, I was gone every week-end doing something. I drove places by myself. I was invited everywhere. I liked myself and other people liked me too. I've lost a lot of friends because of this. You can only ask a person to come over to your house or go out just so many times (after being repeatedly turned down) before they think you don't want to be with them or don't like them any more. It wasn't that I didn't like them, I was just too afraid to tell them.

I went to a party this year, the first one in a long time, at a good friends. We've been friends 12 years but she doesn't know about me . . . . We only stayed an hour and then left. I was uncomfortable all the time and wanted to stay near the door all the time. I know her well enough to know she was hurt. She kept asking, "Why are you so quiet?"

My husband and I have been married two years and we have been out together, perhaps 2 times.

INTERVIEWER: What are you like at present? Do you like yourself?

SUBJECT: No! I like my ideas and think I'm a good person but I don't like myself. The agoraphobia has made me more sensitive to people: handicapped people shut off from the world, people other people don't care about or notice because they are too busy with themselves. . . . and . . . I mean . . . I'm now concerned about what I should have been going for all the way along. Before, there was no church involved in my life. Now there is.

INTERVIEWER: If you made a list of the top ten things that have impacted your life and changed you radically, would the agoraphobia be listed?

SUBJECT: Yes. I was scared to death to drive here to see you.

INTERVIEWER: Does agoraphobia affect a marriage?

SUBJECT: Yes. I feel guilty because I know he (husband) wants to go out. He complains all the time because we don't go out which makes me feel like saying, "Good-bye! Hit the door! I can't do that right now and I can't help it."

A couple of times we've tried to go out to eat and then to a movie. And during the meal I get the attack and I'm too scared to go to the movie. He gets mad because he does not get to go out and I feel like, what's the use. If I can't do that now, I might as well get a divorce. I'm at the point where I don't care. I want to beat this thing, but you

don't just walk in and say, "Good-bye!"

I've had this thing for 7 years and for two of those I stayed in the house . . . . For three months now, this (driving to this office) is the only thing I've done by myself. As long as someone else goes along . . . . I hardly have any real friends. Oh, we do telephone talk, and they want me to come over and do things.

INTERVIEWER: What must your friends think is going on with you?

SUBJECT: One of my friends started crying on the phone and asked, "Why do you always tell me 'No'? Are you mad at me? Finally, I asked her to come to my house. She did and I told her everything. She said, "I'm so glad you told me because I thought you were angry with me." I can see how she would feel that way because, if I knew she was calling me, I would just not answer the phone. I was there and she knew it because all she had to do was drive by and see my car in the driveway. I'm sure it looked like I was avoiding her. Now that she knows, she feels better towards me and we have a real good relationship. I feel so much being honest about the agoraphobia, but there is something that will not let you tell.

INTERVIEWER: What do agoraphobics need from their spouses? What do they need to hear?

SUBJECT: I want to hear that I'm doing good. Even if all I've done is stay home and clean up the house -- positive instead of all the negative. I hear a lot of the negative. There is hardly any positive. After visiting with my psychologist and he tells me about how well I'm doing, I can even go shopping. People married to agoraphobics should say, "If you would like, we could go out to eat." Don't say, "When are we ever going to go out to eat!?" Say, "If you would like, we'll go to the restaurant of your choice." Let the agoraphobic choose where they want to go because they know where they are comfortable. And when you do go out to eat with an agoraphobic and they say, "Could we leave now?" or "Could we go outside and then come back in?" . . . don't throw a fit. This would make it a lot easier.

INTERVIEWER: So, to be understanding and say a lot of positive things makes a difference?

SUBJECT: Yes. Say, "You are doing good" even if you don't mean it. There are days when I am scared all day long . . . like a rabbit. And when I come home I don't need that (negative comments). There are a lot of times when I don't say anything to him about how scared I am. Say we are sitting in a movie -- I just die in movies -- and I get it real bad; I won't say anything because I know all I'll get from him is, "I've just spent $15 on this," etc. When we went to see "Tootsie," he was enjoying the movie so much, laughing and all, and I had a panic attack but said nothing. By the time the movie was over I wanted to go to the emergency room. I'm afraid to say anything because he's not real understanding. He thinks he knows the answer to all of this . . . if someone is frightened of the dark then shove them into the dark! He thinks everybody should be rough and tough and you need to make them tough and

rough. This is not the answer.

INTERVIEWER: How long do you think agoraphobia lasts?

SUBJECT: I think it's like alcoholism: the rest of my life, I'm going to be agoraphobic but I will be controlling it differently rather than running out the door. Only once have I had the big attack -- and that was the first attack -- and ended up running out the door, but I'm afraid I will have that attack again. Since that time I've been preoccupied with death. I try to analyze everything.

INTERVIEWER: Any anger welling up inside you with all this frustration?

SUBJECT: I don't get angry. I try to control it. But when I reach my point it gets ridiculous. After storing it all up, I finally break out screaming at someone.

INTERVIEWER: How are you and your husband getting along with the agoraphobia?

SUBJECT: Not very well. He thinks he is an understanding person, but he isn't. Last night we went out to eat, and in the middle of the meal my knees began shaking. I leaned over and told him I was having trouble breathing. He said, "Christ! You are so stupid!" Then the anger starts and I want to take my sandwich and rub it in his face. Makes me real mad. Then I resent him and don't talk to him. I didn't talk to him after that incident last night. I didn't talk to him this morning -- my way of punishing him. I've never been one to stand up and talk back to anybody. I can't come right out and say, "Stick this sandwich in your ear" -- though I would probably feel better afterwards.

INTERVIEWER: There are some things, then, your husband could change that would make it easier for you?

SUBJECT: When we were dating, he was real nice to me and did not call me any names. He was so positive. I would probably have already been gone, divorce wise, if I were not so scared.

INTERVIEWER: So you are not happy with the marriage?

SUBJECT: No. Just because of the negativeness in it. But the agoraphobia keeps me in it.

INTERVIEWER: Do you, then, talk about the agoraphobia together?

SUBJECT: No. I will start in talking to him but he just sighs. At that, I stop. I think he doesn't want me to get completely well because he knows I would probably leave him. He and I separated in October, 1983 and I went to the State Fair with my son. I wasn't scared. I rode rides and we played games. We had a good time. Going home to him was no good. I want him to leave me alone and quit pushing me. I can't help this.

When I have an assignment from the psychologist to practice going

to a shopping mall, my husband will not go with me. He is either too tired or something else. I think he knows I would leave him if I get over this. I've said it! He responds with, "You couldn't make it on your own. You would fall flat on your face." This makes me mad.

INTERVIEWER: How did your first husband handle your agoraphobia?

SUBJECT: He was very understanding. I remember saying to him, "I feel frightened" and he responded, "I sometimes feel scared, too, but we can make it." He was more understanding than my present husband. Once, while driving to Texas, my first husband drove just as slow as I wanted him to, and neither of us knew what was wrong with me. He would console me and I would do better.

INTERVIEWER: What kind of person does it take to be married to an agoraphobic?

SUBJECT: A strong, strong, unselfish person. The person married to an agoraphobic person will have to give more and receive little in return. While you see daisies and blue skies, we agoraphobics see nothing but gloom and doom. We want the daisies and blue sky but don't know how to get it.

Also, we need a person who will not let us be dependent upon them -- sort of a soft John Wayne type. We need someone who will say, "I'm here if you need me" but not someone who comes running every time you whimper. The husband/wife who is not agoraphobic will be giving up a lot and feeling cheated. I know I would feel cheated if my husband were agoraphobic and I had to stay in town because he just did not feel like going, and sat home watching, "Fantasy Island" repeatedly.

INTERVIEWER: Any particular battle that you are fighting now with the agoraphobia?

SUBJECT: Yes, driving. I can't drive. My mother or husband takes me everywhere.

INTERVIEWER: Yet, you drove to this office?

SUBJECT: But I was angry with my husband. And I don't even know if I will get home. I'm afraid that I will lose control and have to pull off the road and people will think I'm crazy.

Once when I went to the emergency room and a relative had me committed to the psychiatric ward. I know I'm not crazy. Yes, I have emotional problems, but I'm not crazy. My mom will not get out of the house after 7 P.M. and her mother did not get out of the house at all and I don't know about any of the others before.

I don't want this for my child. So when the cub scouts need a den mother and my son asked me to take it, I did. So every Monday afternoon, I have all these little boys and we have to get out and go somewhere. Of course, I stay in this area and on those days when I'm feeling bad, I will take them close to a hospital, Red Cross or a place

where I can get help if I need it. But, I get so engrossed in the boys, I sometimes forget about my problem. I enjoy it. But Friday through Monday I start dreading all those little boys coming to the house. But we go out, I get them home and nothing happens . . . but I imagine all this.

INTERVIEWER: Let's see if we can summarize where you are right now. You are trying to not only be less frightened yourself but are encouraging your son to do things and not be scared. Part of your new life is to get out from under your mother's dominating and protective influence and you are going to move six miles away from her. When are you going to move into the new house?

SUBJECT: We sign the papers on the house today and will move within 30 days. It's going to be good but I'm scared, so scared. All the time, I'm so afraid I'm going to die, that I'm not living. My son has not seen Woodward Park or been to the Zoo because I've been too afraid to take him. I want him to experience Disneyland and I'm planning to take him this summer. Last friday, I enrolled him in Karate classes to help build up his self-confidence. I want him to grow up and move away from me and call me only once a month or so.

INTERVIEWER: I'm so impressed with how hard you are working and how much progress you have made.

SUBJECT: My grandmother, who I loved with all my heart, passed away a year ago and I feel guilty because I was too scared to get out and to go see her a lot. Don't get me wrong, I did go see her but not a lot. I feel guilty about that. Well, my other grandmother is still living and I keep thinking I will go visit her before (she dies) but I don't because I'm scared.

INTERVIEWER: Would you be scared if your husband drove with you?

SUBJECT: No. But he will not go with me. I don't know why he won't, but I've asked him but he says, "I'm too tired" or "I don't want to do that." This only tells me that our marriage is not very good. He only wants to keep our marriage going because he is too proud to admit failure. He would stay in the marriage, right or wrong. I'm sure he thinks he loves me, but he does not know how to treat me. I do a lot of things for my little boy -- scouts, soccer -- but I need to do them for myself.

INTERVIEWER: You rely a lot on your husband, don't you?

SUBJECT: Yes. He does the grocery shopping. I would go only if it meant we could eat.

INTERVIEWER: When you husband is with you, do you "route"?

SUBJECT: No. Usually, I route my trips near a fire station, hospital, doctor's office or Vet Clinic. I'm a "router." When he is with me, I keep my eyes out for medical buildings. When we went to Corpus Christi this summer on vacation, the first thing I did was to look in the

telephone directory for the address of the hospital. I did not know those streets and the address would have done me no good if I needed it, but I had to do it. I knew that just over the bridge from where we were staying there was a sign with an arrow that said, "hospital" in case I needed it. I won't tell my husband I do that, but I do.

INTERVIEWER: You seem to keep a lot to yourself.

SUBJECT: I do and I don't have any respect. I want respect from my family.

INTERVIEWER: I'm not sure I follow you on this respect business.

SUBJECT: It's always, "If you need something or need something done, call (subject's name)." Nobody ever asks me! It is not at all unusual for my mother or my brother to call on my day off with plans they have made for me. I will cancel what I have planned and do what they say.

INTERVIEWER: So you take a lot of guff from people.

SUBJECT: Well, I'm not a martyr or anything, because I get mad, but I just don't tell that person who has done it to me. I will later scream at the kids or my husband.

INTERVIEWER: I wonder why you don't stand up to people and be more assertive?

SUBJECT: Then they would get mad. I just cuss and mumble under my breath and nobody knows. I'm just like Rodney Dangerfield: I don't get no respect.

INTERVIEWER: What would you give to get rid of the agoraphobia?

SUBJECT: Everything . . . . Take every possession I have. I would gladly turn over my paycheck every month. It means a lot to me to get rid of it, because I have taken a second job cleaning so I can pay the psychologist who is helping me. I just want to live. I want to be able to talk to my grandchildren about the flowers, the beaches, and the pretty things in life. I wish I could be hypnotized and wake up having forgotten all this. Or, if I could have amnesia in that part of my brain.

INTERVIEWER: So you would describe agoraphobia . . . .

SUBJECT: It's death! . . . sometimes, I've wondered if it's even worth it.

VITA 2

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